RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6871 5

PLACE OF DEATH
County of Cassia
City of Oakley

Registration District No. 120
Primary Registration District No. 2199
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

46 B

2. FULL NAME Annie Lotisa Anderson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John A Anderson

6. DATE OF BIRTH (month, day and year) June 9 1854

7. AGE — Years: 75 — Months: 6 — Days: 28 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweedyn

PARENTS

10. NAME OF FATHER: Amanual Berg
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER: Caroline Goldenhamer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: J.C.Anderson
(Address): Oakley Idaho.

15. Filed January 7, 1930 — Charles B. Reymer. M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 7 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from January 5, 1930, to January 7, 1930
that I last saw h.er alive on January 7, 12.P, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pthrovic Myocarditis

(duration) yrs. Unknown mos. ds.
CONTRIBUTORY (Secondary) Pthrovic Arthritis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles B. Reymer, M. D.
January 7, 1930 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Ida — Date of Burial: Jan.11 1930

20. Undertaker: D.E.Johnson — Address: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

REC'D JAN 13 1930

1. PLACE OF DEATH

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 68805

Registered No.

County of

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samantha Thomason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1863 (Year)

7. AGE: 66 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: G L P Roberts

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Eliza Merrick

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Robertson

(Address) Gooding Ida.

15. Filed Jan 8 1930 Chas A Zeller Jnc. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

10 1a

16. DATE OF DEATH: Jan (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2nd 1930 to Jan. 8th 1930

that I last saw her alive on Jan. 5 1930

and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. Zeller M. D.

1/8 1930 (Address) Jerome, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: Jan 10 1930

20. UNDERTAKER: D. A. Peterman — ADDRESS: Jerome

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68838

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 181

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chester Laurane Larson

(a) Residence. No. 608 Indiana St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1912 - 3 - 13

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	9	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Frazee - Minn.

PARENTS

10. NAME OF FATHER Andrew Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Julia Bjornsted
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lake Park Minn.

14. Informant Julia Larson
(Address) Coeur d'Alene Ida

15. Filed 1/6, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 - 1 -, 1930, to 1 - 3 -, 1930
that I last saw him alive on 1 - 2 -, 1930
and that death occurred, on the date stated above, at 4:15 P. m.
The CAUSE OF DEATH* was as follows:
General Paralysis.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Teed, M. D.
1-4-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest. Cem. CdAlene	1-5- 1930
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68893

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 406 - 11th St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

2. FULL NAME Henrietta Tunzat
(a) Residence. No. 406 11st St. St. Portland, Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 24 1830
7. AGE Years 89 Months 6 Days 9 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Gustav Naury ok
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Augusta Von Sandere
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. J. O. Rhodes
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 3rd (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1930, to January 3rd, 1930
that I last saw her alive on Jan 2nd, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Heart Block
(duration) yrs. mos. — ds.
CONTRIBUTORY (Secondary) Cerebrals of Hemorrhage
(duration) yrs. + mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) 6 Carson, M. D.
1/3, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland Oregon
Date of Burial 19
20. Undertaker: Brower-Hann Co
Address: Lewiston Idaho

RECEIVED JAN 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68947

PLACE OF DEATH
County of Twin Falls
City of Twin Falls.

Registration District No. 120
Primary Registration District No. 2199

Local Registrar's No. 1

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna Louisa Smith

(a) Residence. No. Twin Falls. Country Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Robert Smith

6. DATE OF BIRTH (month, day and year): Mar. 6, 1880

7. AGE — Years: 49 | Months: 9 | Days: 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Grantsville Ut.

PARENTS

10. NAME OF FATHER: Geo W Whittle
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Ann Jenette Severe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Robert Smith
(Address) Oakley Ida R F D 2

15. Filed January 5, 1930 Charles B. Reymer M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1929, to January 1, 1930
that I last saw her alive on January 1, 1930
and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:
Hyperthyroidism - Adenoma
Thyroid A

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory

(Signed) Charles B. Reymer M. D.
January 4, 1930 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakley Ida R F D 2 — Date of Burial: Jan 4 1930

20. Undertaker: D. E. Johnson — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

J. Bacchs.

68972

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68972

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 5

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B

75

2. FULL NAME Mrs. Winifred A. Sanderson.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Stanley Sanderson.

6. DATE OF BIRTH (month, day and year): March 1st 1905

7. AGE: Years 24, Months 10, Days 4. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sioux City, Iowa.

PARENTS

10. NAME OF FATHER: Fred J. Vetsch.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Adelaide Fiegenbaum.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wis.

14. Informant: Mrs. A. Vetsch.

(Address): Wendall, Idaho.

15. Filed 1-7, 1930 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 6th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan. 6th, 1930 that I last saw her alive on Jan 6th, 1930 and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows: Paralysis (complete)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Multiple Neuritis

(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/7/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wendall, Idaho. Date of Burial: Shipment 1-8 1930

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

68973

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68973

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
(No. 5 Miles S.W. of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Lloyd N. Wheeler

(a) Residence. No. 5 miles S.W. of Boise. St.
(Usual place of abode.)
Length of residence in city or town where death occured 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna E. Wheeler.

6. DATE OF BIRTH (month, day and year) August 29th 1872.

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
57	4	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Saline Co. Neb.

PARENTS

10. NAME OF FATHER Theo M. Wheeler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Conn.
12. MAIDEN NAME OF MOTHER Rhoda C. Beardslee.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Conn.

14. Informant (Address) Mrs. Anna E. Wheeler. Boise, Idaho.

15. Filed 1-20, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 16th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~to~~ ~~, 19~~ ~~I last saw him alive on~~ ~~, 19~~ and that death occurred, on the date stated above, at ~~m.~~

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Found Dead in closed Garage where Automobile was still running at time he was found. Carbon Monoxide gas exhaust from this Automobile

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental — No Inquest No foul play found. No Chels

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —

(Signed) Wm. McBratney, Coroner, M. D.
1/18/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/20/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

68974

RECEIVED FEB 6 1930

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 68974

Registration District No. 127

Primary Registration District No. 2192

Local Registrar's No. 8

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

76

2. FULL NAME AMOS I HUTSON

(a) Residence. No. ..... St. ASHTON IDAHO

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE ~~XXXXX~~

4. COLOR OR RACE WHITE

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 56 Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Poleman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt Vernon Ill

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) --- Unknown

12. MAIDEN NAME OF MOTHER --- Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) --- Unknown

14. Informant Mrs Hoover Att.

(Address) Blackfoot, Ida.

15. Filed Jan 28, 1930. Mrs Hatus E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 25th, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19 to Jan 24th 1930, 19

that I last saw him alive on Jan 24th 1930, 19

and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

~~XXXXXXXXXXXXXXXXXXXX~~

General Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

Dont Know (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Geo. Williams, M. D.

Jan 25th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salt Lake City-Utah

Date of Burial 1-30-1930

20. Undertaker Modern Mortuary

Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 6 1930

PLACE OF DEATH

County of Idaho

City of Grangeville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 1001

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

6849-75

DO NOT WRITE IN THIS SPACE

State File No. 68975

Local Registrar's No. 2

2. FULL NAME Albron Foster Parker 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary M Parker

6. DATE OF BIRTH (month, day and year) 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work County Official Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Sylvia Mulhall
(Address) Grangeville Idaho

15. Filed 2-4-1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 4- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to Jan. 3-, 1930
that I last saw him alive on Jan 3. 1930
and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows: Organic Heart Lesion

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of Heart

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Enlarged Heart

(Signed) B. Chipman, M. D.

1-12-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	1-6-1930
20. Undertaker	Address
Hemlock Mtd. Co	Grangeville Ida.

Lyle 68978

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68978

PLACE OF DEATH

County of Nez Perce.

City of Lewiston. (Orchards).

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Charles Irwin Chase.

(a) Residence. No. St. Orchards.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20th, 1896.

7. AGE Years: 33. Months: -8- Days: -9- If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Genesee, Idaho.

PARENTS

10. NAME OF FATHER A. L. Chase.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salem, Oregon.

12. MAIDEN NAME OF MOTHER Lilly Whitcomb,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) California.

14. Informant A. L. Chase.
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930 Susan E Burns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Dec, 1929, to Jan 29, 1930 that I last saw him alive on Dec. 20, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Lyle, M. D.

1/30/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 1/31/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

Lyle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston (Orchards)

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Irwin Chase

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/20/1896

7. AGE 33 Years | Months 8 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Genesee Idaho

PARENTS

10. NAME OF FATHER A. L. Chase

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salem Oregon

12. MAIDEN NAME OF MOTHER Lilly Whitcomb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) California

14. Informant A. L. Chase
(Address) Lewiston, Idaho

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan. 2, 1930
that I last saw him alive on Dec 28, 1929
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Lyle, M. D.

1/30, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho | Date of Burial 1/30 1930

20. Undertaker Brower-Wann Co | Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

PLACE OF DEATH

County of Lincoln

City of Shoshone

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

68979

DO NOT WRITE IN THIS SPACE

State File No. 68979

Registration District No. 16

Primary Registration District No.

Local Registrar's No. 2

(No. Burdette Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Richard Pohjola

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Finlander

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Gustave Pohjola

6. DATE OF BIRTH (month, day and year): Feb 6 1863

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
66	11	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Orivetilla Finland

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Gustave Pohjola by Red Cross

(Address) Ex Secy Astoria Oregon

15. Filed Jan 7 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Jan 6, 1930

that I last saw him alive on Jan 6, 1930

and that death occurred, on the date stated above, at 12:15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 9 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy Exam

(Signed) T. E. Barrett, M. D.

Jan 7, 1929 (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Ida

Date of Burial: Jan 7 1930

20. Undertaker: C. E. Hickok

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

68980

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68980

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

38

2. FULL NAME Harry L. Croshaw

(a) Residence. No. ..... St. Rupert, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Miller

6. DATE OF BIRTH (month, day and year)

7. AGE: 39 Years | Months: 9 | Days: 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stationary Eng.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Geo. Croshaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Susan Castle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant J. F. Barsinger Att.
(Address) Blackfoot, Ida

15. Filed Jan 29, 1930 Mrs Hales E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 28, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1929, 19 ..., to Jan 28 1930, 19 ...
that I last saw him alive on Jan. 28, 1930, 19 ...
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Syphilis

Dont know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Wassermann
(Signed) Geo. Williams, M. D.
Jan 28, 1930, 19 ... (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Idaho | Date of Burial: Jan 30 1930

20. Undertaker: E. J. Peck | Address: Blackfoot

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68981

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 33
(No. 1602 N. 20th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a B

2. FULL NAME Mrs. Merle Martin Powell

(a) Residence. No. 1602 N. 20th St.
(Usual place of abode.)
Length of residence in city or town where death occured 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas George Powell.

6. DATE OF BIRTH (month, day and year) June 12th 1892

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
37	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portland, Oregon.

PARENTS

10. NAME OF FATHER J. L. Martin.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon.
12. MAIDEN NAME OF MOTHER Jerusha Hays.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant Thomas G. Martin.
(Address) Boise, Idaho.

15. Filed 1-31, 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 28, 1930, to January 28, 1930
that I last saw her alive on January 28, 1930
and that death occurred, on the date stated above, at 6-05 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 2 hours

CONTRIBUTORY (Secondary) Hypertension
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Hemiplegia

(Signed) W. W. Corbett M. D.
1/29/30, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/31/30 19
Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Springer

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68983

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. B31
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44B

2. FULL NAME Charles Anderson.
(a) Residence. No. Sweet, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Della Anderson.

6. DATE OF BIRTH (month, day and year) March 14th 1864

7. AGE Years 65 Months 10 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS
10. NAME OF FATHER Andrew Anderson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweden.

14. Informant (Address) Mrs. Charles Anderson. Sweet, Idaho.

15. Filed 1-29, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 27th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1930, to Jan 27, 1930
that I last saw him alive on Jan 27, 1930
and that death occurred, on the date stated above, at 1:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
chronic myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) arterio sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J S Springer, M. D.
1/27/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Sweet, Idaho. Date of Burial Shipped 1/28/30 19

20. Undertaker Wm. McBratney Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68984

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 36
(No. 2010 N. 16th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170 B

2. **FULL NAME** Donald Munson
(a) Residence. No. 2010 N. 16th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 26th 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	7	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In High School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell, Idaho.

PARENTS

10. NAME OF FATHER Frank Borkenhagen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) St. Louis, Mo.
12. MAIDEN NAME OF MOTHER Ida Tollin.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Clay Center, Kan.

14. Informant (Address) D. F. Munson, Boise, Idaho.

15. Filed 1-28, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ----------, 19--, to ----------, 19--
that I last saw him alive on ----------, 19--
and that death occurred, on the date stated above, at 1:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Suicide = Shot himself in right temple with 22 Caliber rifle.
Died Instantly (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) No Inquest held (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No. Date of ---
Was there an autopsy? No
What test confirmed diagnosis? ---
(Signed) W McBratney, Coroner, M. D.
1/27/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 1/28/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68985

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 29
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164 B

2. **FULL NAME** Mrs. Mellissa Yeager.
(a) Residence. No. 2710 W. Jefferson St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elijah Yeager.

6. DATE OF BIRTH (month, day and year) February 14th 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	11	10	------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Andrew J. Green.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Lucinda Blizzard.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Va.

14. Informant (Address) Mrs. J. T. LaRose Eureka, Calif.

15. Filed 1-25, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 24th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1930 to Jan 24th, 1930 that I last saw her alive on Jan 24th, 1930 and that death occurred, on the date stated above, at 6 P.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senile Dementia - senility
Hypertension -

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bouk, M. D.
1/25/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 1/27/30 19
20. Undertaker Wm. McBratney. Address Boise, Ida.

N. B.—Every item of information should be carefully [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68986

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

B 74a

2. FULL NAME Young Howard Abercrombie

(a) Residence, No. 2506 Woodlawn St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Alice Abercrombie

6. DATE OF BIRTH (month, day and year) Oct 3 - 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	3	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cement Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10. NAME OF FATHER Clements Abercrombie
11. ~~BIRTHPLACE~~ OF FATHER (city or town) (State or Country) ?
12. ~~MAIDEN~~ NAME OF MOTHER ?
13. ~~BIRTHPLACE~~ OF MOTHER (city or town) (State or Country) ?

14. Informant Mrs. Carl Abercrombie
(Address) 1413 E. State St.

15. Filed 1-24, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Jan 20, 1930
that I last saw him alive on 1-20, 1930
and that death occurred, on the date stated above, at 3:15 P. m.
The CAUSE OF DEATH* was as follows: Hemiplegia, Due to Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Acidosis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Clinical Symptoms
What test confirmed diagnosis?
(Signed) W. D. Craigie, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/23 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68987

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

32 B

2. FULL NAME Charles Edward Shaver

(a) Residence. No. ..... St. Emmett Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 20-1925

7. AGE: 4 Years | Months: 1 | Days: — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ola Idaho

PARENTS

10. NAME OF FATHER: F. E. Shaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country): [illegible]
12. MAIDEN NAME OF MOTHER: Inez M[illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): [illegible]

14. Informant: Felix E. Shaver
(Address) Emmett Idaho

15. Filed 1-22, 1930 W. H. Rhodes Registrar
P.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Jan. 20, 1930
that I last saw him alive on Jan 20, 1930
and that death occurred, on the date stated above, at 9:57 a. m.
The CAUSE OF DEATH* was as follows:
Acute Miliary Tuberculosis
Probable (duration) — yrs. 4 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Emmett Idaho
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Radiographs. Autopsy
(Signed) Harmon Trenlame, M. D.
Jan 22, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Ida | Date of Burial: 1/23 1930

20. Undertaker: C. D. Buckman | Address: Emmett Idaho

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 68988

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 26
(No. 1310 N. 13th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Lucinda Isabel Stiles.
(a) Residence. No. 1310 N. 13th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MB B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Gustavus C. Stiles.

6. DATE OF BIRTH (month, day and year) August 15th 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lawrence, N. Y.

PARENTS

10. NAME OF FATHER Alonzo Gorton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Eleanor Perry
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Paris, France.

14. Informant (Address) Mrs. Carl Cadwell. Boise, Idaho.

15. Filed 1-21, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 16th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 16, 1930
that I last saw her alive on Jan 16, 1930
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis (chronic)
(duration) ~~[illegible]~~ yrs. mos. ds. to my knowledge

CONTRIBUTORY (Secondary)
Influenza (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. M. Holverson, M. D.
1/17/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 1/21/30 19

20. Undertaker Wm. McBratney.
Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68989

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

B 305a

2. FULL NAME Theo Ramey

(a) Residence. No. 1119 N. 15 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of T. Scott Ramey

6. DATE OF BIRTH (month, day and year) Dec. 12, 1896

7. AGE Years 33 Months 1 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Charles F Baker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Theo M Ramey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mos.

14. Informant T. Scott Ramey
(Address) 1119 N. 15 St Boise Idaho

15. Filed 1-21, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from nov. 1929, to Jan 20, 1930.
that I last saw her alive on 1-19-, 1930
and that death occurred, on the date stated above, at 6 00 a.m.
The CAUSE OF DEATH* was as follows:
Generalized sarcoma. Inguinal Lymph glands first noticed - prob. arising abdominal Lymph glands Diag. Lymphs - Sarcoma (duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Montana
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X-ray
(Signed) Gerald T. Nokes, M. D.
1-20-, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan 22 1930

20. Undertaker: Summers & Krebs
Address: Boise Idaho

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

RECEIVED SEP 6 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

68989

Dr. H T Nokes
Boise

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Theo Ramey who died at Boise, Idaho on Jan. 20, 1930
Cause of death given as "Generalized Sarcoma."

Information DESIRED in order to complete certificate:

PLEASE STATE THE PRIMARY SEAT OF THE DISEASE.

PLEASE ANSWER BELOW:

Inguinal Lymph Glands first noticed Feb. Arising from Same Locus in Abdominal Lymph Glands.
Diag.- Lympho-Sarcoma.

Dr. Fred T. Nokes

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6899 0

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1094

Local Registrar's No. 24

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

B 30-a

2. FULL NAME Edward Steckel.

(a) Residence. No. 2111 Bannock St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 8-1872.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	10	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Placerville Idaho

PARENTS

10. NAME OF FATHER Dave Steckel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant James E Fox

(Address) 2111 Bannock St Boise Ida

15. Filed 1-21, 1930 W. B. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to January 21, 1930 that I last saw him alive on Jan. 20, 1930 and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Pyemia

(duration) yrs. 21 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harold W Tom M. D.

1-21, 1930 (Address) 317 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 23 1930

20. Undertaker: Summers & Kretz — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68991

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 23
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 90

2. FULL NAME George Doebler

(a) Residence. No. 625 South 16th St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. — mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 20 - 1846

7. AGE: Years 83 | Months 9 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining and
(b) General nature of industry, business, or establishment in which employed (or employer): Ranching
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hamburg, Germany

PARENTS

10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Otto Kuenzler
(Address) 2502 Fairview ave. Boise

15. Filed 1-15, 1930 — W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 9, 1930
that I last saw him alive on Jan 9, 1930
and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease
& Influenza

(duration) 5 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bubacute
Myocarditis (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) J. M. Brayton M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/12 1930

20. Undertaker: Schreiber & McCann — Address: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68994

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 20

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 107

2. FULL NAME Mrs. Sarah Elizabeth Eytchison.

(a) Residence. No. 2723 W. Bannock St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Eytchison

6. DATE OF BIRTH (month, day and year): December 10th 1859

7. AGE: Years 70 | Months 1 | Days 3 | If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10. NAME OF FATHER: Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): "

14. Informant: Pearl Allen.
(Address): Boise, Idaho

15. Filed 1-14, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 13th 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 1/9, 1930, to 1/13, 1930 that I last saw her alive on 1/12, 1930 and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Throat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart Broc. Valvular Heart

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab. Findings

(Signed) Fred. A. Pettengill, M. D.

1/13, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. | Date of Burial: 1/15/30 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

PLACE OF DEATH

County of Ada.

City of Boise.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 68995

Local Registrar's No. 19

748 B

2. FULL NAME Bert R. Davis.

(a) Residence. No. Boise, Idaho. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 45			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Pearl Allen.

(Address) Boise, Idaho.

15. Filed 1-13, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 9th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 9, 1930

that I last saw him alive on Jan 9, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Attorney, M. D.

1/10/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
County Cemetery	1/13/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68996

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 17

(No. 1110 Franklin Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 2-

2. FULL NAME Mrs. Catherine M. West.

(a) Residence. No. 1110 Franklin Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3rd 1860

7. AGE Years	Months	Days	If LESS than 1 day, ---hrs.--- or ---min.
69	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Salt Lake City, Utah
(State or country)

PARENTS

10. NAME OF FATHER W. T. Van Noy.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER Catherine Hendricks.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know.

14. Informant I. N. Nash.
(Address) 1110 Franklin Street.

15. Filed 1-11, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to Jan 10, 1929
that I last saw her alive on Jan 6, 1929
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Bulbar Paralysis.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) Fred A. Fitzgerald, M. D.
1/10/30, 19.... (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/12/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68997

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 16

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44 B

2. FULL NAME Mrs. Rose Hallford.

(a) Residence. No. Idaho City, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Newt Hallford.

6. DATE OF BIRTH (month, day and year) January 15th 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	11	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Granite City, Idaho.

PARENTS

10. NAME OF FATHER Phillip Ranft.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Katherine Kool.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs. Rhoda Hall.

(Address) Idaho City, Idaho.

15. Filed 1-11, 1930 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1929, to Jan 10, 1930
that I last saw h er alive on Jan. 9. , 1930
and that death occurred, on the date stated above, at 4:30 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach & metastasis

(duration) 1 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at her home
Did an operation precede death? Yes Date of Sept-26,1929
Was there an autopsy? No
What test confirmed diagnosis? Pathologic Section
(Signed) H.E. Bradshaw, M. D.
1/10/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	1/12/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

Wahle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68998

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 15 B
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Diana Elizabeth McDowell

(a) Residence. No. 49 St. Star Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles McDowell

6. DATE OF BIRTH (month, day and year) Sept 8-1873

7. AGE: Years 56 | Months 4 | Days 0 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John Beemus
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Charles McDowell
(Address) Star Idaho

15. Filed 1-11, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Jan 8, 1930
that I last saw h[illegible] alive on Jan 8 1930
and that death occurred, on the date stated above, at 6 15 6 m.

The CAUSE OF DEATH* was as follows:
Metastatic
Carcinoma in Lungs
from Carcinoma of Left Breast
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? yes Date of Apr 1929
Was there an autopsy? no
What test confirmed diagnosis? X Ray & Post
(Signed) W H Wahle M. D.
____, 19____ (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cemetery — Date of Burial: Jan. 12 1930
20. Undertaker: Summers & Rube — Address: Boise Idaho

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68999

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 14

(No. Salvation Army Maternity Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B
160

2. FULL NAME Martha Jean Brownell.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year) January 6th 1930

7. AGE: Years 0 | Months 0 | Days 4 | If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: Mark M. Enswiler.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: Rena Florence Brownell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Delta, Colo.

14. Informant: Rena F. Brownell.
(Address) Boise, Idaho.

15. Filed 1-11, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 10th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930 to Jan 10, 1930

that I last saw h~~e~~ alive on Jan 10, 1930

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Congenital defect of heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Suroney, M. D.

1/10/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: County Cemetery. | Date of Burial: 1/11/30 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69000

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

B

194

2. FULL NAME John E. Forester.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. / mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ----------

6. DATE OF BIRTH (month, day and year): April 15th 1891

7. AGE: 38 Years, Months: 8, Days: 16. If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sharpsburg, Pa.

PARENTS

10. NAME OF FATHER: John Forester.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Mrs. Nell McCarthy.
(Address): Bend, Oregon.

15. Filed 1-11, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 1st 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 , to , 19~~ ~~that I last saw h alive on , 19~~ ~~and that~~ death occurred, on the date stated above, at about 11⁰⁰ A m.

The CAUSE OF DEATH* was as follows: Stabbed with Knife cutting through Liver, Pancreas, and puncturing a branch of the Oorta Died about 3½ hours after Stabbing (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Homicide. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? Yes Date of 1/1/30
Was there an autopsy? Yes by Dr Stone & Dr Allen
What test confirmed diagnosis? ——
(Signed) W McBratney, Coroner ~~M.D.~~
1/10/30, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Johns Cemetery — Date of Burial: 1/9/30 19

20. Undertaker: Wm. McBratney. — Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

PLACE OF DEATH

County of Ada.

City of Boise.

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69001

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 12

(No. 119 South 27th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B
205-B

2. FULL NAME Jack Thomas.

(a) Residence. No. 119 south 27th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 3rd 1930

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	4	----------

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Ben Thomas.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad, Idaho.

12. MAIDEN NAME OF MOTHER Rachael Moon.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Malad, Idaho.

14. Informant Ben Thomas.

(Address) Boise, Idaho.

15. Filed 1-11, 1930 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 7th 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~that I last saw h~~ ~~alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at about 4:40 A.M. m.

The CAUSE OF DEATH* was as follows:

Unknown. No Doctor was in attendance at time of Birth or at time of Death nor had a Doctor attended it during its 4 Days of Life.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Child seemed Normal in every way.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of ----

Was there an autopsy? No ----

What test confirmed diagnosis? ----

(Signed) Wm McBratney Coroner ~~M. D.~~

1/7/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery

Date of Burial: 1/7/30 19

20. Undertaker: Wm. McBratney.

Address: Boise, Idaho.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69002

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

131 B

2. FULL NAME George Osich
(a) Residence. No. 111 So 13th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About Years 66 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Croatia

PARENTS
10. NAME OF FATHER: Tony Osich
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Croatia
12. MAIDEN NAME OF MOTHER: Not Obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Croatia

14. Informant: Mike Osich
(Address) 111 So 13st Boise Ida

15. Filed 1-10, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 5, 1930 that I last saw him alive on Jan 5, 1930 and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
1. Uremia
(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) 2. Cancer of prostate
(duration) 2 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Lyman T. West, M. D.
1-7, 1929 (Address) 4138 Eastman.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Johns Cemetry
Date of Burial: 1-8-1930

20. Undertaker: Schreiber & McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

Goodfriend

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69003

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 10
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 129

2. FULL NAME George H. Hodge
(a) Residence. No. 608 Idaho St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan-5-1845
7. AGE Years 85 Months 0 Days 1 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER George Hodge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George H. Hodge
(Address) 608 Idaho Street, Boise Ida

15. Filed 1-9, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th, 1929, to Feb 5th, 1929
that I last saw h— alive on Feb 4th, 1929
and that death occurred, on the date stated above, at 2 9 m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
3 (duration) 5 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 4 yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Goodfriend, M. D.
Jan 8, 1930 (Address) Overland Bldg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Fourth Idaho
Date of Burial Jan 9 1930
20. Undertaker Summers & Krebs
Address Boise Ida

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stone

DO NOT WRITE IN THIS SPACE
State File No. 69004

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1094
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. B 9

2. FULL NAME Herman E. Gustafson

(a) Residence. No. ..... St. Hailey Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept-17-1872

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Finland

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Emerald Irwin
(Address) Hailey Idaho

15. Filed 1-8-1930 W. R. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1930, to Jan 3, 1930 that I last saw h[illegible] alive on Jan 3, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes no Date of Dec. 29, 29
Was there an autopsy?
What test confirmed diagnosis? Biopsy

(Signed) Harold W. Lane M. D.
1/8, 1930 (Address) Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan 9 1930
20. Undertaker	Address
Summers & Krebs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69005

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 8
(No. Salvation Army Maternity Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1612 B

2. FULL NAME Kenneth Smith.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) January 4th 1930

7. AGE Years	Months	Days	If LESS than 1 day,
0	0	0	5 hrs. or 45 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Kenneth Hines.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Marion Beale Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls, Idaho.

14. Informant Pearl Allen.
(Address) Boise Idaho

15. Filed 1-7, 1930 U.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Jan 4, 1930
that I last saw h[illegible] alive on Jan 4, 1930
and that death occurred, on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓

(Signed) Attorney, M. D.
1/7/30, 19 (Address) ~~Boise~~, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
County Cemetery	1-8-30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69006

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 7

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 109 B

2. FULL NAME Margaret Little

(a) Residence. No. 310 South 17th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) October 17th 1928

7. AGE: Years 1, Months 2, Days 20. If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise, Idaho.

PARENTS

10. NAME OF FATHER: Frank Little.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Meta George.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York.

14. Informant: Frank Little.
(Address) Boise, Idaho.

15. Filed 1-7, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 7th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6 P.M. Jan. 6, 1930, to Jan 7, 1930 that I last saw her alive on Jan 7, 19 and that death occurred, on the date stated above, at 5:30 A.M. m.

The CAUSE OF DEATH* was as follows:
An acute hemorrhagic infection of unknown nature, starting probably in naso-pharynx.
Acute (duration) 0 yrs. 0 mos. 18 hours

CONTRIBUTORY (Secondary) Sudden marked reduction in milk in hardest (duration) 0 yrs. about 21 ds.

18. Where was disease contracted if not at place of death? 310 So 17th St. Boise

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hemorrhagic diathesis

(Signed) Harmon A. Tremaine, M. D.
1/7/30, 19 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 1/8/30 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69007

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

1281 B

2. FULL NAME Mrs. Mary Farrell

(a) Residence. No. ..... St. Idaho City, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Farrell

6 DATE OF BIRTH (month, day and year): March 25 1868

7 AGE: Years 61 | Months 9 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS
10 NAME OF FATHER: Frank German
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Dena Blenica
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: D. J. Farrell
(Address): Idaho City, Ida

15 Filed 1-7, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 2 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jan 2, 1930 that I last saw her alive on Jan 2, 1930 and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

acute nephritis + uraemia
Streptococcic meningitis
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): uraemia
..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no Laboratory
What test confirmed diagnosis? urine analysis Spinal puncture
(Signed) G. H. Ward, M. D.
Jan 3, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: St. John's Cemetery
Date of Burial: 1/7 1929

20. Undertaker: Schreiber & McCann
Address: Boise I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69008

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 4

118a B

2. FULL NAME Frank J. Thomas

(a) Residence. No. Eagle Ida Rt 1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Wht.
5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 14 - 1859

7 AGE: Years 69 | Months — | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penni.

PARENTS
10 NAME OF FATHER: Adolphus Thomas
11 BIRTHPLACE OF FATHER (city or town) (State or country): Penni.
12 MAIDEN NAME OF MOTHER: Eva Ingham
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penni.

14 Informant: T. W. Thomas
(Address) Eagle Idaho

15 Filed 1-6, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan. (Month) 5 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 5, 1930, that I last saw him alive on Jan 5, 1930, and that death occurred, on the date stated above, at 9:40 A. m.

The CAUSE OF DEATH* was as follows:
Operation for strangulated inguinal hernia
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Gall stones - abdominal adhesions (duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eagle Ida
Did an operation precede death? Yes Date of Dec 30-29
Was there an autopsy? Yes
What test confirmed diagnosis? Operation + autopsy
(Signed) J. Reno Numbers, M. D.
Jan 5, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 1/7 1930

20. Undertaker: Schreiber & McCann
Address: Boise Ida

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69009

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 3
161a
B

2. FULL NAME Mary Bengoechea (infant)

(a) Residence. No. St. Lukes Hosp. St. Mtn. Home
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 19, 1929

7 AGE Years Months Days 14 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS
10 NAME OF FATHER Luis Bengoechea
11 BIRTHPLACE OF FATHER (city or town) (State or country) Boise, Idaho
12 MAIDEN NAME OF MOTHER Anna Yturri
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mtn Home

14 Informant Ines Yturri
(Address) 1317 Bannock

15 Filed 1-6, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 2 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from December 19, 1930, to January 2, 1930, that I last saw him alive on January 2, 1930, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:
Premature 6 67 mos taby
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia in mother
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W Stone, M. D.
1/4, 1930 (Address) 317 Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: St. Johns Cemetery
Date of Burial: 1/3 1930

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69011

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 1

(No. St Alphonsus Hospital 4
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gwendolyn Wells Beck

(a) Residence. No. ..... St. Mayfield Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 25-1920

7. AGE Years	Months	Days	If LESS than 1 day,
9	0	6,	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER James O. Beck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise Idaho,
12. MAIDEN NAME OF MOTHER Gladys Wells
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant I O Beck
(Address) Mayfield Idaho

15. Filed 1-2, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1-1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1929, to Jan 1, 1930
that I last saw her alive on Jan 1, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
atopic scarlet fever
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Eva Callister M. D.
....., 19..... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan 2 1930
20. Undertaker	Address
Summers & Kirby	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69012

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. B 13

(No. U.S.Vet. Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

888

2. FULL NAME Charles E. BRADISH

(a) Residence. No. Orofino, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. x yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) 3-27-1847

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	10	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) *Name of employer*

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant M.Cornelius

(Address) U.S.V.B., Boise, Idaho

15. Filed 1-31, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 15, 1930, to January 30, 1930

that I last saw him alive on January 30, 1930

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

General debility

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory & autopsy

(Signed) P. C. Smith, M. D.

Jan. 30, 1930, 19... (Address) Regional Medical Off. U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino, Idaho — Date of Burial: Shipped 1/31/30 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] FEB 5 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69013

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004.
Local Registrar's No. 12
(No. 1 1/2 Miles E of Meridian)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188a B

2. FULL NAME Harvey David Tittle.
(a) Residence. No. 3 Miles W of Boise St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Nov 3 - 1873
7. AGE: Years 56, Months 2, Days 24. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10. NAME OF FATHER: William M. Tittle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Frances Border
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Dick A Tittle
(Address) RD # 2, Boise Idaho

15. Filed 1 - 30 1930 W. H. Rhodes Registrar
R 8

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 27 - 1930 (Month) (Day) (Year) 19
17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 , to , 19~~ ~~that I last saw it alive on , 19~~ ~~and that~~ death occurred, on the date stated above, at 12.30 P. m.
The CAUSE OF DEATH* was as follows: Accidently Killed by Railway train. In auto—
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
Inquest held 1/29/30 (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Due Verdict.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Tw McBrahney - Coroner
1/29/30, 19 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan 30 1930
20. Undertaker: Summers & Krefs
Address: Boise Idaho

Dr. Parker

RECEIVED FEB - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69014

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 10
(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31 B

2. FULL NAME Clifton Eneas.

(a) Residence. No. Lapwai, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	Indian	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) 1911

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Conesse, Idaho.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant Mr. Cribbins.
(Address) Boise, Idaho.

15. Filed 1-25, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 24th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Jan. 24, 1930
that I last saw him alive on Jan. 23, 1930
and that death occurred, on the date stated above, at 2:40 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
I don't know duration Was very ill in Oct 1929 (duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) —
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? I don't know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O H Parker, M. D.
1/25/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 1-26 1930
20. Undertaker Wm. McGratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Taylor

DO NOT WRITE IN THIS SPACE
State File No. 69015

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 9

PLACE OF DEATH
County of Ada
City of Boise
(No.) Idaho Soldiers Home
(If death occurred in a hospital or institution, give its name instead of street and number.)

103 B

2. FULL NAME William Henry Aiken

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 1840

7. AGE	Years	Months	Days	If LESS than 1 day,
	89	8	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Jra Aiken
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Agnes Weston
(Address) 1414 N 8 Street Boise Ida

15. Filed 1-23, 1930 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 21, 1930, to Jan 21, 1930
that I last saw him alive on Jan 21 1930
and that death occurred, on the date stated above, at 12, 30 P. m.

The CAUSE OF DEATH* was as follows:
Congestion of Lung -

48 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) J. M. Taylor - M. D.
Jan 23rd, 1930 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan 24 1930
20. Undertaker	Address
Summers & Krebs	Boise Ida

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69016

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

B
90

2. FULL NAME Saloma Jane Cleveland
(a) Residence. No. Near Franklin School
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-8-1852

7. AGE: Years 77, Months 11, Days 5. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tennessee

PARENTS
10. NAME OF FATHER: Henry B. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn
12. MAIDEN NAME OF MOTHER: Nancy Pickens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): South Carolina

14. Informant: Grover E. Cleveland
(Address) RD # 2. Boise Idaho

15. Filed 1-14, 1930 W. H. Rhodes R.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 13 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 10th, 1929, to Jan 13th 1930
that I last saw her alive on October 10th, 1930
and that death occurred, on the date stated above, at 8,200 m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease - Slight blood pressure - pyloric stenosis of stomach.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Emaciation -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Thos Book, M. D.
Jan 14, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Jan 15 1930

20. Undertaker: Seemmers & Krebs.
Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

PLACE OF DEATH
County of Ada
City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 69017

Local Registrar's No. 6

B 158

2. FULL NAME Jean A. Brunner

(a) Residence. No. 3/4 Mile North of Ada St. County Hospital
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Brunner

6. DATE OF BIRTH (month, day and year) July 11 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	5	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER Robert Henderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Isabelle Allan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Alexander Brunner.
(Address) R.D. # 1. Boise Idaho

15. Filed 1-9, 1930 W. N. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Jan 8, 1930
that I last saw h-er alive on Jan 8, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Chronic arthritis Deformans
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) Fred A. Illingte M. D.
1/9, 1930 (Address) Boise Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan 11 1930

20. Undertaker Summers & Krebs Address Boise Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69018

RECEIVED FEB 5 1930

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
(No.)
Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead of street and number.)

4 A B 13

2. FULL NAME George L. Ricketts

(a) Residence. No. 3 Miles W of Boise on Valley road.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1856,

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown,

14. Informant Geo. L. Ricketts Jr.
(Address) Kansas City Mo.

15. Filed 1-8, 1930 W. H. Rhodes Registrar
R. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1 (Month) 8 (Day) 29 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 8, 1930
that I last saw h[illegible] alive on 1/7, 1930
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Dilatation (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) Fred A Pilling M. D.
1/8, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Jan. 10 1930
20. Undertaker	Address
Summers & Tibbs.	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69019

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 4
(No. 13)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mary Elizabeth Wartman

(a) Residence. No. Valley View 8 mi NW of Boise
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 7 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER John Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No Record
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) No Record

14. Informant Mrs. J. M. Cecil.
(Address) Boise Idaho RR 1

15. Filed 1-7-1930 W. N. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
1/1/29, 19..., to ..., 19...
that I last saw her alive on — , 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) Fred A Pettingill, M. D.
1/6, 1930 (Address) Boise 2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Joplin Cemetery	1/8 1930
20. Undertaker Schreiber & McCann	Address Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69020

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 3
(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Wm. R. JURRIES

(a) Residence. No. Parma, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. X yrs. X mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Julia Jurries

6. DATE OF BIRTH (month, day and year) 1-24-1896

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	11	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pharmacist
(b) General nature of industry, business, or establishment in which employed (or employer) OSM
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Matin Co., Minn.

PARENTS
10. NAME OF FATHER Herman Jurries
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Kitserow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant M. Cornelius
(Address) U.S.Vet. Bureau, Boise, Idaho

15. Filed 1-6, 1930 W. T. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 6, 1930 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1930, 19, to Jan. 6, 1930, 19
that I last saw him alive on Jan. 6, 1930, 19
and that death occurred, on the date stated above, at 6:45 A.M. m.

The CAUSE OF DEATH* was as follows:
Acute myocarditis secondary to
acute alcoholism.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) XX
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX
Did an operation precede death? XX Date of
Was there an autopsy? XX
What test confirmed diagnosis? XX

(Signed) F. C. Smith, M. D.
1-6-30, 19 (Address) Reg.Med.Off. U.S.V.B. Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma, Idaho	1-8 1930
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69021

PLACE OF DEATH

County of Ada
City of West of City

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 3

164

2. FULL NAME Julius Miller

(a) Residence. No. Ada Co. Gary Station
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Miller

6 DATE OF BIRTH (month, day and year): July 7-1858

7 AGE: Years 71 | Months 5 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer and
(b) General nature of industry, business, or establishment in which employed (or employer): Stock Raiser
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10 NAME OF FATHER: Henry Miller
11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland
12 MAIDEN NAME OF MOTHER: Barbara [illegible] ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Jesse Miller
(Address) Meridian Ida Rt 1

15 Filed 1-4, 1930 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 1 (Month) - 3 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to Jay 2, 1929, that I last saw him alive on Jay 1, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Amyloid degeneration

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Geo Collester M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Dry Creek Cemetery
Date of Burial: 1-5 30

20 Undertaker: Schreiber McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69022

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 1

(No. U.S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129 16

2. FULL NAME Otis Wainwright SHANER

(a) Residence. No. Green River, Utah St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6. DATE OF BIRTH (month, day and year): Sept. 26, 1899

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	30	3	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tractor driver

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John W. Shaner

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky Pa.

12. MAIDEN NAME OF MOTHER: Elizabeth Hinds

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa.

14. Informant: M. Cornelius

(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 1-2, 1930 W. W. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 5, 1929, to Jan. 1, 1930,
that I last saw him alive on Jan. 1, 1930,
and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis
Chronic interstitial hepatitis with
ascites with secondary anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? xx Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F. C. Smith, Reg. Med. Officer, M. D.
1-2-30, 19 (Address) U.S.V.B. Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ainsworth, Nebraska — Date of Burial: Shipped 1-3-30

20. Undertaker: Wm. M. Bradley — Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69023

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004

Local Registrar's No. 18

(No. 164 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary E. Williams

(a) Residence. No. 2717 West Bannock St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. H. Williams

6. DATE OF BIRTH (month, day and year) April 27-1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Keokuk, Iowa

PARENTS

10. NAME OF FATHER Mr. Bradley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ans.

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ans.

14. Informant Florence Shea
(Address) Boise, Ida

15. Filed 1-13, 1930 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 7, 1930, that I last saw h— alive on Jan 5, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee Causta, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	1/9 1930
20. Undertaker	Address
Schneider & Williams	Boise

Collector

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69024

PLACE OF DEATH
County of Ada
City of Star

Registration District No. 9+10
Primary Registration District No. 9+10
Local Registrar's No. 88
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 a

2. FULL NAME Eleanor P. Green
(a) Residence. No. Star, Ida, St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Israel J Green
6. DATE OF BIRTH (month, day and year) July-25-1844
7. AGE Years 85 Months 5 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Pleasant Plane Iowa
PARENTS
10. NAME OF FATHER William Pickard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Mary Jane Bell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana
14. Informant J. W. Jones
(Address) Star Ida
15. Filed 1/15, 1930 Orvie Jackson Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 12, 1930
that I last saw her alive on Jan 9, 1930
and that death occurred, on the date stated above, at 7-a. m.
The CAUSE OF DEATH* was as follows:
Double lobar pneumonia
senile type
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) H. M. Holverson, M. D.
Jan 27, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Star Cemetery
Date of Burial Jan 14 1930
20. Undertaker G. V. Peckham
Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. [illegible] RECEIVED FEB 3 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9-10
Primary Registration District No. 9-10
File No. 69025
Registered No. 87

1. PLACE OF DEATH.

County of Ada
City of Star
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriett Lutcase Brashears

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec 14 (Month) ..... (Day) 1863 (Year)

7. AGE: 66 Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Died Jan 10 1930 at Hocolek
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Polk Co Missouri

10. NAME OF FATHER: Eliga Bass

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Martha Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J B Brashears
(Address) Star

15.
Filed 1-11 1930
Orrie Fulton
Local Registrar
Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jany - 10 (Month) ..... (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1918, to Jany 10 1930, that I last saw h alive on Jany 9 1930 and that death occured on the date stated above, at 3 4 M.

The CAUSE OF DEATH* was as follows:
Arthritis Deformans
(Duration) Many Yrs. - mos. ..... ds.
Contributory (Secondary) Pleural abscess
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C C Hall M D
1/10 1930 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: 1-11 30

20. UNDERTAKER: Hamer & Tuck — ADDRESS: Boise

SYMS - YORK CO., PTGS. & ENGS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

PLACE OF DEATH

County of Ada

City of Meridian Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 11

Primary Registration District No. 2003

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69026

Local Registrar's No. 1

88 B

2. FULL NAME Mary Blanche Reese

(a) Residence. No. Meridian Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A-W-Reese

6. DATE OF BIRTH (month, day and year) August 10th 1879

7. AGE: Years 50 | Months (5) | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clairmount Mo

PARENTS

10. NAME OF FATHER Gilbert Campbell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill- --

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant A. W. Reese

(Address) Meridian Idaho

15. Filed 1-12, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jun (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/8-, 1930, to 1-10, 1930

that I last saw her alive on 1-10, 1930

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows: Myo Carditis with gas pressure following obstruction

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal obst 4 days — (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H F Neal, M. D.

1-11, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery | Date of Burial: Jan 14 1930

20. Undertaker: [illegible] Meridian Id | Address

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69027

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

49

2. FULL NAME Elsie B. Lembke

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. J. F. Lembke

6. DATE OF BIRTH (month, day and year) Sept 26, 1887

7. AGE Years 42 Months 4 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clarion Iowa

PARENTS
10. NAME OF FATHER Edward Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary J. Dean
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chilkenville Ind.

14. Informant Mrs Ella Hemstead
(Address) Meridian Ida

15. Filed 1-30, 1930 H. F. Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1930, to Jan 29, 1930
that I last saw her alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Carsinoma of stomach & liver
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. F. Neal, M. D.
Jan. 30, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery
Date of Burial: 2-1 1930

20. Undertaker: B. W. Robison
Address: Meridian Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 29 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69027

Dr. H.F. Neal
Meridian

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Elsie B. Lembke who died Jan. 29, 1930 at Meridian, Idaho
Cause of death given as "Carcinoma"

Information DESIRED in order to complete certificate:

WILL YOU PLEASE STATE THE PRIMARY SEAT OF THE DISEASE?

PLEASE ANSWER BELOW:

Carcinoma of stomach & liver

H.F. Neal

FEB 24 1987
NOV 17 1981

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11

Primary Registration District No. 2003

(No. ....., ... St.)

File No. 69028

Registered No. 3

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Earl Wardle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 28 (Day) 1930 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Meridian, Idaho

10. NAME OF FATHER: Atheamer Wardle

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rose Alice Powell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A H Wardle

(Address) Meridian Ida

15.

Filed 2-2 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 1 (Day) 1930 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28 1930, to Feb 1 1930, that I last saw him alive on Jan 31 1930, and that death occurred on the date stated above, at 6 45 A M.

The CAUSE OF DEATH* was as follows:

Prematurity; 7 mo gestation

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel A Swayne M. D.

Feb 1 1930 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery

DATE OF BURIAL: 2-2 1930

20. UNDERTAKER: B W Robison

ADDRESS: Meridian Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69030

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5748

71B

2. FULL NAME Marion Bringhurst

(a) Residence. No. Springfield, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1, 1920.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	9	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) At School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield, Idaho.

PARENTS

10. NAME OF FATHER William W. Bringhurst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Nellie Madsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant William W. Bringhurst
(Address) Springfield, Idaho.

15. Filed 1-27, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 25, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 25, 1930
that I last saw h[er] alive on Jan 24, 1930
and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:
Acute Staphylococcic Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Acute Mastoiditis
(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death? Springfield Idaho
Did an operation precede death? No Date of Jan 17 Jan 18
Was there an autopsy? Yes
What test confirmed diagnosis? Bacteriological

(Signed) C. W. Pond, M. D.
1/27/30, 19____ (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	1/27/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69031

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5747

(No. St Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME George A. Ernest

(a) Residence, No. 912 N. 9 St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Mar 4 - 1840

7. AGE: 89 Years, 10 Months, 15 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Butcher
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Geo A. Ernest

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs M. J. Gilmore
(Address) 912 N. 9 City

15. Filed 1-28, 1930. J. Homer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 19, 1930
that I last saw him alive on Jan 19, 1930
and that death occurred, on the date stated above, at 6 a m m.

The CAUSE OF DEATH* was as follows:
Hypostatic pneumonia
Lobar

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fracture neck left femur
Slipped & fell on ice at his home (duration) ..... yrs. ..... mos. 11 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) A.M. Newton, M. D.

Jan 24, 1930 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View
Date of Burial: Jan 22 1930

20. Undertaker: Schumacher Beasley
Address: City

RECEIVED APR 28 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

69031

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

A.M. Newton
Pocatello, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

George A. Ernest who died at Pocatello, Idaho on Jan. 19, 1930
Cause of death given as "Hypostatic Pneumonia, lobar." "Fracture neck of Femur"

Information DESIRED in order to complete certificate:

WILL YOU PLEASESTATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Slipped and fell on the ice at his home

A. M. Newton M.D.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69033

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5745

(No. 1018 North Ninth Ave. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

848

2. FULL NAME William Henry Firkins

(a) Residence. No. 1018 North Ninth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Smithhurst

6. DATE OF BIRTH (month, day and year) July 17, 1867.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	6	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah.

PARENTS

10. NAME OF FATHER Joseph F. Firkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Webb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant E. P. Firkins
(Address) Castleford, Idaho.

15. Filed 1-22, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 18, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929 to Jan 18, 1930
that I last saw h[illegible] alive on Jan 20, 1930
and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:
Mitral Stenosis - Lesion of valves (Myocarditis)

(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Rematic Fever
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical only.

(Signed) James F. Millis M. D.
1 / 22 / 30, 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	1/22/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69034

Local Registrar's No. 5744

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216-1
(No. ..... If death occurred in a hospital or institution, give its name instead instead of street and number.)

161a

2. FULL NAME James Keaton Jr

(a) Residence. No. 228 N 5th St.
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Wh	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day and year)

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10 NAME OF FATHER James E. Keaton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky
12 MAIDEN NAME OF MOTHER Ruby Blalock
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant W P Bealock
(Address) Pocatello Idaho

15 Filed Jan 21, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to 1-20, 1930,
that I last saw h[illegible] alive on 1-20, 1930,
and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows: Premature birth 6 mo

(duration) ... yrs. ... mos. 14 hours

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...

(Signed) D C Roy, M. D.
1-21, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial: Jan 21 1930

20. Undertaker: H. L. McHan — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69035

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Ranch North of Poca. City)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5743

2. FULL NAME Syble Lucile Christensen

100a

(a) Residence. No. Ranch North of Pocatello, City. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) December 31, 1921

7. AGE

Years	Months	Days	If LESS than 1 day
8	0	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): At School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Idaho.

PARENTS

10. NAME OF FATHER: Willard R. Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hyrum, Utah.
12. MAIDEN NAME OF MOTHER: Della Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Willard R. Christensen
(Address) Ranch North of Pocatello, City

15. Filed 1-16, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Jan 15, 1930
that I last saw her alive on Jan 14, 1930
and that death occurred, on the date stated above, at 16. m.
The CAUSE OF DEATH* was as follows:

[signature]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) [signature] M. D.
1/16/30, 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery
Date of Burial: 1/17/30 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69036

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 216/

Local Registrar's No. 5742

(No. 1234 South Fifth Ave. Poca. Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME Sadie Rungren

(a) Residence. No. 1234 South Fifth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Rungren

6. DATE OF BIRTH (month, day and year) Oct. 4, 1870.

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	3	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Isaac Daniels

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Ida. Steed

(Address) 1234 So. Fifth Ave. Poca. Ida.

15. Filed 1-11, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 5, 1930, to Jan. 10, 1930

that I last saw he alive on Jan 10, 1930

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia-Lobular

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory & clinical

1 / 11 / 30 (Signed) J. L. Miller, M. D.

(Address) Poca. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	1/12/30. 19

20. Undertaker Arthur W. Hall Address Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69038

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2-16-1
Local Registrar's No. 570
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Margaret Y. Bowen

(a) Residence. No. Arbon, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of D. J. Bowen

6. DATE OF BIRTH (month, day and year) Nov. 22, 1860.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Perry, Utah.

PARENTS

10. NAME OF FATHER Thomas Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Hay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant D. J. Bowen
(Address) Arbon, Idaho.

15. Filed 1-11-30 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8, 1930, to 1-10, 1930
that I last saw her alive on 1-10, 1930
and that death occurred, on the date stated above, at 8:30 a.m.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Chronic nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
1/11/30., 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Brigham City, Utah	On Arrival 19
20. Undertaker Arthur W. Hall	Address Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69039

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5739

(No. 308 North Ninth Ave. Poca.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Thomas Shaw

(a) Residence. No. 308 North Ninth Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

180a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Adeline Douglas

6. DATE OF BIRTH (month, day and year): April 27, 1873.

7. AGE

Years	Months	Days	If LESS than 1 day,
56	8	12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Office Man

(b) General nature of industry, business, or establishment in which employed (or employer): Water Dept.

(c) Name of employer: City of Pocatello

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: William Shaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Morton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Joseph Wright
(Address) 308 North Ninth Ave. Poca. Ida.

15. Filed 1-9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 8, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Jan 8, 1930
that I last saw him alive on Jan 8, 1930
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/9/30., 19 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery

Date of Burial: 1/10/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69040

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216/1
Local Registrar's No. 5738

(No. 538 No. Hayes Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph M. Larson

49

(a) Residence. No. 538 North Hayes Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 6, 1874.

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	2	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Paint Shop Foreman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country): Newton, Utah.

PARENTS

10. NAME OF FATHER: Peter Larson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary Benson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City, Utah.

14. Informant: Mrs. Joseph M. Larson
(Address) 538 No. Hayes Ave. Poca. Ida.

15. Filed 1-6, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 6, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-6, 1930, to 1-6, 1930
that I last saw h alive on 1-6, 1930
and that death occurred, on the date stated above, at 2.30 A m.
The CAUSE OF DEATH* was as follows:

Congestion pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature], M. D.
1/6/30, 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Utah.	On Arrival

20. Undertaker	Address
Arthur W. Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69041

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5727

131

2. FULL NAME Katie York

(a) Residence. No. American Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 17th 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	9	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Leon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Geo York
(Address) American Falls Ida

15. Filed 1/3, 1930 J. H. Toomey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 3, 1930
that I last saw h[illegible] alive on Jan 3, 1930
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:
Uraemia Poisoning.

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Partial intestinal obstruction
[illegible] (duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. M. Newton, M. D.
Jan 3, 1930 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
American Falls Ida	1-6 1930
20. Undertaker Davis	Address Am. Falls.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69044

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 25
Primary Registration District No. 161
Local Registrar's No. 761

(No. 227 North Johnson Ave. (IN Rear)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barbra Ann Olsen

100a

(a) Residence. No. South Idaho Street, Poca. Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 8, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	0	6	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER R. C. Olsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pocatello, Ida.
12. MAIDEN NAME OF MOTHER Edrie Christofferson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pocatello, Idaho.

14. Informant R. C. Olsen
(Address) South Idaho Street, Pocatello, Ida.

15. Filed ____, 19____ ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febuary 8, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/5/30, 19____, to 2/8/30, 19____
that I last saw h[illegible] alive on 2/9/30, 19____
and that death occurred, on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Acute Bronchial Pneumonia
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. R. Loomis, M. D.
2/10/30. 19____ (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	2/10/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
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RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Dr Gunn

DO NOT WRITE IN THIS SPACE
State File No. 69045

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5760

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 257 Wilson)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Jeff Moroni W Sherwood

(a) Residence. No. 257 Wilson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 7th

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Stillborn			3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country)

PARENTS

10. NAME OF FATHER M. W. Sherwood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Pearl Dye.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant M W Sherwood
(Address) Pocatello Ida

15. Filed ....., 19....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/7, 1930, to 2/8, 1930, that I last saw h[illegible] alive on 2/8, 1930 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) C C Gunn, M. D.
2/8, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	2/8 1930
20. Undertaker	Address
Johnson & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69046

PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Primary Registration District No. 216.1

Local Registrar's No. 5754

(No. General Hospital) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charles Harbig

(a) Residence. No. ____ St. Rockland, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 24.1912

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	17	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work On Farm

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer E.M.Harbig
Idaho

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER E.M.Harbig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Minn

12 MAIDEN NAME OF MOTHER Elle Commick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Minn

14 Informant E. M. Harbig.
(Address) Rockland, Idaho

15 Filed 2/7, 1930 J. H. Young. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 6 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 2-4, 1930, to 2-6, 1930,
that I last saw h[illegible] alive on 2-6, 1930,
and that death occurred, on the date stated above, at 6 P. m.

The ~~CAUSE~~ OF DEATH* was as follows: Endocarditis myocarditis

(duration) ____ yrs. ____ mos. 21 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ____ yrs. ____ mos. ? ds.

18 Where was disease contracted if not at place of death? Lava Hot Springs

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/6, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Am Falls, Idaho	2-9 1930

20. Undertaker Address American Falls Ida

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69047

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 852 So. 2nd Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5758

31

2. FULL NAME Mrs Trig. Torres

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Mexican	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Pres. Torres. Davis

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	10	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Old Mexico

PARENTS

10. NAME OF FATHER ~~Pres~~ Savado Torris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Old Mexico

12. MAIDEN NAME OF MOTHER Tomassa

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Old Mexico

14. Informant Pres Torris Davis
(Address) Pocatello. Idaho

15. Filed Feb 5, 1930. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~ Feb. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/2, 1930, to 2-4, 1930
that I last saw h~~er~~ alive on 2/2, 1930
and that death occurred, on the date stated above, at 5:45 P. m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) ..... M. D.
Feb 6, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello. Idaho	Feb 6 1930
20. Undertaker	Address
McHan Undt Co	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69048

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5757

48R

2. FULL NAME Harry Thomas Lockyer

(a) Residence. No. McCammon, Idaho. St. McCammon, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29, 1912.

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	6	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Robin, Idaho.

PARENTS

10. NAME OF FATHER Benjamin Lockyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Lydia Crowshaw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond, Utah.

14. Informant Mrs. Lydia Lockyer
(Address) McCammon, Idaho.

15. Filed Feb, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febuary 5, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/4, 1930, to 2-5-30, that I last saw him alive on 2-5-30, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Epilepsy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) , M. D.
2/6/30., 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Robin Cemetery, Robin, Ida.	2/8/30 19

20. Undertaker Arthur W. Hall — Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69050

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2
Primary Registration District No. 2161
(No. 749 North Tenth Ave. Poca.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5755

90

2. FULL NAME Arvilla P. Griffith
(a) Residence. No. 749 North Tenth Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4, 1922.

7. AGE: Years 7, Months 6, Days 28. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): At School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS
10. NAME OF FATHER: John T. Griffith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Frisco, Utah.
12. MAIDEN NAME OF MOTHER: Edna Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Newton, Utah.

14. Informant: Mrs. John T. Griffith
(Address) 749 North Tenth Ave. Poca. Ida.

15. Filed 2/4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febuary 2, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Feb 2, 1930
that I last saw her alive on Feb 2, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Charea-Rheumatism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Phy Exam
(Signed) [signature], M. D.
2/3/1930, 19__ (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery
Date of Burial: 2/5/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69051

PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

Registration District No. 2

Primary Registration District No. 2161

Local Registrar's No. 5754

(No. Riverside Hotel, Lava Hot Springs)

(If death occurred in a hospital or institution, give its name instead of street and number.)

66

2. FULL NAME Jack Moore John Albert Moore

(a) Residence. No. Jackson Hole, Wyoming. St. Jackson Hole, Wyo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: About Years 50 Months Days If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cattle Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Arthur W. Hall

(Address) Coroner of Bannock Coumty

15. Filed 2/6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Feb 1, 1930

that I last saw him alive on Feb 1, 1930

and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows: Moonshine Poisoning

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Jackson Wyo.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C.A. Rich, M. D.

2-2-, 1930 (Address) Lava Hot Spgs.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery

Date of Burial: 2/6/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69052

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5753

57

2. FULL NAME Mary Kathryn Donahue
(a) Residence. No. Dickey Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 15th 1924
7. AGE Years 5 Months 1 Days 17 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mackay Idaho
PARENTS
10. NAME OF FATHER Dennie Donahue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mackay Idaho
12. MAIDEN NAME OF MOTHER Ella Hunter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Blackfoot Idaho
14. Informant Dennie Donahue
(Address) Dickey Idaho
15. Filed 2/1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 1, 1930
that I last saw her alive on Feb 1, 1930
and that death occurred, on the date stated above, at 5:45 P m.
The CAUSE OF DEATH* was as follows:
Diabetic Coma
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood sugar test
(Signed) Wrong test A. M. Newton, M. D.
Feb 1, 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mackay Idaho Date of Burial Feb 4 1930
20. Undertaker Chumacher & Beasley Address City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69053

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 25
Primary Registration District No. 2161
Local Registrar's No. 5752

(No. 231 North Third Ave. Poca.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arnold Savage

(a) Residence. No. 231 North Third Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Savage

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About	72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri.

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Wallace Martin
(Address) 301 North Third Ave. Poca. Idaho.

15. Filed 2/1, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 27, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 17, 1930
that I last saw h[illegible] alive on Jan 17, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(duration) yrs. 3 mos. — ds.
CONTRIBUTORY (Secondary) agl
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? — —
What test confirmed diagnosis? Examination
(Signed) J. H. Lyon, M. D.
2/1/1930, 19 (Address) Poca. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	2/2/1930.19

20. Undertaker: Arthur W. Hall — Address: Pocatello.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69054

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5751
(No.) St. Anthonys Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Joseph McCauley 117

(a) Residence. No. 3410 S. 9 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha McCauley

6. DATE OF BIRTH (month, day and year) April 3 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	8	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Daniel McCauley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Johannah Farrell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs Bertha McCauley
(Address) Pocatello Ida

15. Filed 1/31, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Jan 30, 1930
that I last saw him alive on Jan 30, 1930
and that death occurred, on the date stated above, at 5 10 a.m.

The CAUSE OF DEATH* was as follows:
Gangrenous affection of finger with
General peritonitis
Am. of finger directory was done
Jan 1930 29 (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) e
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. J. Rees, M. D.
Jan 31, 1930 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	Feb 3 1930
20. Undertaker	Address
Schumacher & Beasley	City

RECEIVED FEB 14 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69055

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 333 West Fremont Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5756

2. FULL NAME Bertha Hutchings

101a

(a) Residence. No. 333 West Fremont St. Poca. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. J. Hutchings

6. DATE OF BIRTH (month, day and year): December 26, 1889.

7. AGE: Years 40, Months 0, Days 29. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Preston, Idaho.

PARENTS

10. NAME OF FATHER: Robert Anthony
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Mary Egbert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Mrs. C. H. Thompson
(Address) 333 West Fremont St. Poca. Ida.

15. Filed 1-28, 1930. J. R. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 25, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from On Jan 24, 1930, to Jan 25, 1930
that I last saw her alive on Jan 24, 1930
and that death occurred, on the date stated above, at Jan 25 4 pm.
The CAUSE OF DEATH* was as follows:
Labor Pneumonia
I do not know when the disease was contracted
~~I do not~~ I saw her only once (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pocatello Idaho
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. J. Raaf, M. D.
1/28/30. 1930 (Address) Poca. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery
Date of Burial: Jan 28 1930

20. Undertaker: Arthur W. Hall
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69056

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 216

Local Registrar's No. 5749

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Albert Roy. Berry

(a) Residence. No. Glennsferry Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mabel Fletcher

6. DATE OF BIRTH (month, day and year): Feb 3rd, 1892.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	11	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: O. S. L. fireman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Udall Kansas

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: General Hosp.

(Address): Pocatello —

15. Filed 1-28, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 26th, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23, 1930, to 1-26, 1930

that I last saw him alive on 1-26, 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [signature] M. D.

1/28, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glennsferry Idaho

Date of Burial: Jan 30 1930

20. Undertaker: Arthur W. Hall

Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 4 1930

PLACE OF DEATH

County of Bannock

City of Central

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 216

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69057

Local Registrar's No. 174

71B

2. FULL NAME Dan Mathews

(a) Residence. No. Central St. Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 31-23

7. AGE Years	Months	Days	If LESS than 1 day,
6		25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Provo – Utah

PARENTS

10. NAME OF FATHER Lewis C. Matthews

11. BIRTHPLACE OF FATHER (city or town) (State or Country) American Fork - Utah

12. MAIDEN NAME OF MOTHER Evangeline Trimble

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salix Iowa

14. Informant L C Matthews

(Address) Central Idaho

15. Filed Jan. 25, 1930 Mrs. J. J. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Jan. 25, 1930

that I last saw him alive on Jan. 24, 1930

and that death occurred, on the date stated above, at 5:08 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos 10 ds.

18. Where was disease contracted if not at place of death? Same

Did an operation precede death? Spinal Puncture only

Was there an autopsy? No

What test confirmed diagnosis Microscop. Spinal fluid

(Signed) Russell Tigert, M. D.

Jan. 25, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial, Cremation~~, or Removal	Date of Burial
Provo Utah	Jan 29 1930

20. Undertaker E W Hutchinson Address Soda Springs

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69058

PLACE OF DEATH
County of Bannock
City of Inkom

Registration District No. 84
Primary Registration District No. 2161
(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 173

2. FULL NAME Ona June Pratt

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6. DATE OF BIRTH (month, day and year) Jan 25 1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	0	5.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Downey Idaho

PARENTS

10. NAME OF FATHER Heber George Pratt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Downey Ida
12. MAIDEN NAME OF MOTHER Laura Leona Gooch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Thomas Idaho

14. Informant H. G Pratt By C.A Rich
(Address) Inkom Ida

15. Filed Jan-31, 1930 Mrs G. J. Fitt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1930 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 30, 1930
that I last saw her alive on Jan 29, 1930
and that death occurred, on the date stated above, at 4:45 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination
(Signed) C A Rich, M. D.
1-30, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69059

Local Registrar's No. 172

PLACE OF DEATH
County of Bannock. Registration District No. 84
City of Lava Hot Springs Primary Registration District No. 2161
(No.) 1012
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rozlenda Godfrey.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE~~ of Thomas Henry Godfrey

6. DATE OF BIRTH (month, day and year) June 21 1869

7. AGE

Years	Months	Days	If LESS than 1 day,
60	6	10.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: None.

9. BIRTHPLACE (city or town) (State or country): Clarkston Utah.

PARENTS

10. NAME OF FATHER: John Kasper Soosle.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Annie Elizbeth Hunsbacker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland.

14. Informant: F H Godfrey
(Address): Lava Hot Springs Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Jan 1, 1930
that I last saw her alive on Jan 1, 1930
and that death occurred, on the date stated above, at 8:10 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 10. ds.
CONTRIBUTORY (Secondary) Gall bladder trouble
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination
(Signed) C A Rich, M. D.
1-2-, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69060

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 140

2. FULL NAME Mrs. Marie Kensley Wilker 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Wm Henry Wilker
6. DATE OF BIRTH (month, day and year): Oct 16, 1842
7. AGE: Years 87 | Months 3 | Days 8 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Oberbalding Germany

PARENTS
10. NAME OF FATHER: Mathew Kensley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Katharina Lohrer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Frederick C. Wilker
(Address) 108 McKinley Ave Pocatello
15. Filed 1-27, 1930. Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 24 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1929, to January 23, 1930
that I last saw her alive on January 23, 1930
and that death occurred, on the date stated above, at 1:00 P. m.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilitation
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Arterial Hypertension
(duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? BP 150 Sowering Pregnancy Chronic Interstitial Nephritis Edema of Lungs
(Signed) Spencer H. Bright M. D.
January 24 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: January 28 1930
20. Undertaker: Edw. T. Shepherd — Address: Paris Idaho

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69062

PLACE OF DEATH
County of Bear Lake
City of Bloomington
Registration District No. 63
Primary Registration District No.
Local Registrar's No. 141
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Ray Thomas Painter

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3d 1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Diamondville Wyo

PARENTS

10. NAME OF FATHER E F Painter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington Idaho
12. MAIDEN NAME OF MOTHER Martha Patterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bloomington Idaho

14. Informant Geo K Ward
(Address) Bloomington Ida

15. Filed 1-27, 1930 Mrs J. Hunsaker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930 to Jan 29, 1930
that I last saw him alive on Jan 28, 1930
and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:
Pneumonia LLL

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) C O Wood M. D.
1/30, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Idaho	1-31-1930
20. Undertaker	Address
John Hulme	Ida Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69063

PLACE OF DEATH

County of Bingham

City of Blackfoot.

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Wyland Nephi Shore

(a) Residence. No. West Broadway St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 18. 1929.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	8	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Robert Nephi Shore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah,

12. MAIDEN NAME OF MOTHER Edna Maxwell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Nephi Shore
(Address) Blackfoot. Ida.

15. Filed Jan 30, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Jan 27, 1930 that I last saw him alive on Jan 27, 1930 and that death occurred, on the date stated above, at 6:50 P m.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical examination and symptoms

(Signed) W. R. Eagan D.O., ~~M. D.~~

Jan 29, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetary

Date of Burial: 1-30- 1930

20. Undertaker: Modern Mortuary

Address: Blackfoot. Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

PLACE OF DEATH

County of Bingham

City of Blackfoot.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69064

Local Registrar's No. 10

2. FULL NAME Joseph Williams

(a) Residence. No. Blackfoot. R.F.D. St. 92

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Williams

6. DATE OF BIRTH (month, day and year) June, 21, 1866.

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	7	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Thomas Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Harriett Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Jos Williams

(Address) Blackfoot. Ida

15. Filed Jan 30, 1930 Wallace E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 27, 1930

that I last saw him alive on Jan 26, 1930

and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Iliac artery (Left)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + myocarditis

(duration) yrs. 6 mos. ds. to my knowledge

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W W Beck, M. D.

Jan 28, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moreland Cemetary	19

20. Undertaker	Address
Modern Mortuary	Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69065

PLACE OF DEATH
County of Bingham
City of Woodville

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

49

2. FULL NAME Colleen Anderson
(a) Residence. No. Woodville, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10, 1927

7. AGE Years 2 Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Woodville, Idaho

PARENTS
10. NAME OF FATHER Lewis K. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mt Pleasant, Utah
12. MAIDEN NAME OF MOTHER Eva Mathews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Woodville, Idaho

14. Informant Lewis K Anderson
(Address) Shelley R 1

15. Filed Jan 29, 1930 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to Jan 27, 1930
that I last saw her alive on Jan. 29, 1930
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Optic Nerve
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Meningitis
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes No Date of Aug 4-29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. E. Roberts, M. D.
Jan 28, 1930 (Address) Shelley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial Jan 29 1930

20. Undertaker Jack A. Wood Address Idaho Falls

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69066

PLACE OF DEATH
County of BINGHAM
City of BLAC FOOT
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 7.
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mike Egan 76

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	54			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Common laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant J. V. Torrey ATT.
(Address) Blackfoot, Idaho.

15. Filed Jan 13 1930 Mrs Hales E Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 23rd, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1927, 19 to Jan 23rd 19 30
that I last saw him alive on Jan 22nd, 1930, 19
and that death occurred, on the date stated above, at 5:40 AM m.
The CAUSE OF DEATH* was as follows:

Paralysis of insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams M. D.
Jan 23rd, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cemetary	19

20. Undertaker Marion Clark Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69067

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 6
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88a

2. FULL NAME WILLIAM A GILMAN

(a) Residence. No. ..... St. BOISE IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant Fred Hayes
(Address) Blackfoot, Ida.

15. Filed Jan 22, 1930 Mrs Charles E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: JAN 22nd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..., to Jan 22, 1930, 19...
that I last saw him alive on Jan 21st 1930, 19...
and that death occurred, on the date stated above, at 6:45 A m.
The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) C. P. Williams M. D.
Jan 22nd, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Highland Cemetery	19
20. Undertaker	Address
Marion Clark	Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69068

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

743

2. FULL NAME WALTER McCLURE

(a) Residence. No. ..... St. MERIDIAN IDA
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 43 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of ELIZABETH McCLURE

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER J.H. McClure
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Carry Mann
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant G. Baysinger Att.
(Address) Blackfoot, Ida.

15. Filed Jan 21, 1930 Mrs Walter E Pabst
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 21st, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1929, 19 to Jan 21 1930, 19
that I last saw him alive on Jan 21st 1930, 19
and that death occurred, on the date stated above, at 6:15 A m.
The CAUSE OF DEATH* was as follows:

Cerebral embolism & thrombus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Jan 21st, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Meridian Idaho	
20. Undertaker	Address
E. J. Funk	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69069

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 4
(No.) 148 c
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dora Orilla Butler

(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 31, 1908

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22		8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labor in pea factory
(c) Name of employer Rodger Bros. Seed Co.

9. BIRTHPLACE (city or town) Delta
(State or country) Colo.

PARENTS

10. NAME OF FATHER Ralph Francis Butler
11. BIRTHPLACE OF FATHER (city or town) Colo.
(State or Country)
12. MAIDEN NAME OF MOTHER Carrie L. Beckley
13. BIRTHPLACE OF MOTHER (city or town) Delta
(State or Country) Colo.

14. Informant R. F. Butler
(Address) Idaho Falls

15. Filed Jan 10, 1930 Helen E. Petrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 8. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Unaviodable accident in auto on Yellowstone Highway.
Verdict of Coroners jury.
Fracture of temporal bone of skull.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) Ray McClellan
Jan. 10. 1930 Coroner of Bingham County.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: January 11 1930
20. Undertaker: E. J. Peck — Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69070

PLACE OF DEATH

County of Bingham

City of Shelley

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 3

(No. .....)

(If death occurred in a hospital ~~or institution, give~~ its name instead of street and number.)

2. FULL NAME Ella Christena Young

(a) Residence. No. Shelley St. 100a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 12-28-29

7. AGE Years Months Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work bake

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Ida.

PARENTS

10. NAME OF FATHER Chas R Young.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Huntington Utah

12. MAIDEN NAME OF MOTHER Christina Gilbert.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Troy Town Pa.

14. Informant Chas R Young

(Address) Shelley Ida.

15. Filed Jan 7, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-28-, 1929, to 1-6-, 1930

that I last saw her alive on 1-6, 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition (Bottle fed)

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin Cutler, M. D.

1-7-, 1929 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Cemetery

Date of Burial 1-7-1930

20. Undertaker none

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69073

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

124

2. FULL NAME Mrs Hellen Dodson
(a) Residence. No. St Maries Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Murray Dodson

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 37, Months 3, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Gust Halgren
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Christian
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Murry Dodson
(Address): St Maries

15. Filed Feb. 1st, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-20, 1929, to 1-7, 1930
that I last saw her alive on 1-8, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Pelvic Peritonitis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Haemorrhage from gastric ulcer.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G G Espe, M. D.
1/7, 1930 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: Feb 10 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69074

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

74a

2. FULL NAME George Patzer
(a) Residence. No. ..... St. Santa Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Idiven Patzer

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 64 | Months 11 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Blackwell Timber Co

9. BIRTHPLACE (city or town) (State or country): Unknown Germany

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs Geo Patzer
(Address) Fernwood

15. Filed Jan 31, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 21, 1930
that I last saw him alive on Jan 21, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. Cornwall, M. D.
1/22, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fernwood - Santa
Date of Burial: 1/23 1930

20. Undertaker: Geo E Mitchell
Address: St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69075

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2025
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

184C

2. FULL NAME Evan L. Eldredge

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred Eldredge

6. DATE OF BIRTH (month, day and year): Apr 18 – 1899

7. AGE: Years 30, Months 9, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Carey – Ida

PARENTS

10. NAME OF FATHER: Ira Eldredge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Coleville – Utah –
12. MAIDEN NAME OF MOTHER: Marcia Rice
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Farmington – Utah

14. Informant: Ira Eldredge
(Address): Carey Idaho

15. Filed 2 – 1, 1930 R. H. Wright – Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 28, 1930
that I last saw him alive on Jan 28, 1930
and that death occurred, on the date stated above, at 12.55 P. m.
The CAUSE OF DEATH* was as follows: Fracture of skull from auto mobile accident

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. Wright, M. D.
1/28, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey Idaho — Date of Burial: Jan 30 1930

20. Undertaker: Harris & Amos — Address: Hailey

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6976

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No.)
Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lois Madelan Rockwell

(a) Residence. No. 98B Fox St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Oct 10. 1916

7. AGE: Years 13 | Months 3 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Ray J Rockwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Hazel S Fleming
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: R. J. Rockwell
(Address): Jerome, Idaho

15. Filed 2-1, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 25, 1930
that I last saw her alive on Jan 25, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. W. Fox, M. D.
1/28, 1930 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho | Date of Burial: Jan 28 1930

20. Undertaker: Harris & Amos | Address: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69077

PLACE OF DEATH
County of Blaine
City or Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. 161A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Bruce Thomson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			7

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bellevue, Idaho

PARENTS

10. NAME OF FATHER John Arthur Thomson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plymouth Wisc
12. MAIDEN NAME OF MOTHER Jeanette McComb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hendricks Wisc

14. Informant J. A. Thomson
(Address) Bellevue, Idaho

15. Filed 2-1, 1930 W. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 17, 1930
that I last saw him alive on Jan 17, 1930
and that death occurred, on the date stated above, at 12 midnight
The CAUSE OF DEATH* was as follows:
Premature Baby - Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C. W. Post, M. D.
1/18, 1930 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69079

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

118B

2. FULL NAME Oliver Aberham Duquette

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Feb 13 - 1876

7. AGE: Years 53, Months 9, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho City Ida

PARENTS

10. NAME OF FATHER Oliver A. Duquette
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Ladhoff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Margaret Plummer
(Address) Hailey Ida

15. Filed 2-1, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 14, 1930
that I last saw him alive on Jan 14, 1930
and that death occurred, on the date stated above, at 10.40 P.m.
The CAUSE OF DEATH* was as follows:
Obstruction of bowel with strangulation through Omental adhesion
..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 1/12-30
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) E. Wyt, M. D.
1/15, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho City Ida. Date of Burial: Jan 18th 1930

20. Undertaker: Harris & Amos Address: Hailey Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69080

PLACE OF DEATH

County of Boise
City of Idaho City

Registration District No. 8
Primary Registration District No. 2004

Local Registrar's No. 11

(No. 161a B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Quinn

(a) Residence. No. Idaho City, Ida St. Idaho City
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan - 24 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho City, Ida
(State or country)

PARENTS

10. NAME OF FATHER Lawrence B. Quinn

11. BIRTHPLACE OF FATHER (city or town) Horse Shoe Bend
(State or Country)

12. MAIDEN NAME OF MOTHER Gertrude Fairchild

13. BIRTHPLACE OF MOTHER (city or town) Placerville
(State or Country) Idaho

14. Informant Annie Quinn
(Address) 1111 - N. 6th St -

15. Filed 1-27, 1930 W. N. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 24, 1930 to , 19
that I last saw her alive on January 24, 1930
and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:
Premature birth - 7 months

(duration) yrs. mos. 6 hours

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) W. D. Forbush, M. D.

1/26, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	1/26 1930
20. Undertaker	Address
Schreiber & McCann	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69081

Registration District No. 80
Primary Registration District No. 2137
Local Registrar's No. 3

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

46

PLACE OF DEATH

County of Bonner
City of Clarksfork

2. FULL NAME Mrs Stella Vogel

(a) Residence. No. Clarksfork Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Herman Vogel

6. DATE OF BIRTH (month, day and year) March 1871

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	9		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wisconsin
(State or country)

PARENTS

10. NAME OF FATHER Bowen

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Unobtainable

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) "

14. Informant Herman Vogel
(Address) Clarksfork Idaho

15. Filed Jan 27, 1930 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Oct 30, 1929
that I last saw her alive on Oct 30, 1929
and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteris

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) A P Ross, M. D.
1/25, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hope Cemetery	Jan 26 1930
20. Undertaker	**Address**
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 5 1930

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69082

PLACE OF DEATH
County of Bonner
City of Clarkfork
Registration District No. 80
Primary Registration District No. 2107
Local Registrar's No. 2

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Howard

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

197

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James Howard

6. DATE OF BIRTH (month, day and year): Unk

7. AGE: Years: about 45 | Months: | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Unk

PARENTS

10. NAME OF FATHER: Unk
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unk
12. MAIDEN NAME OF MOTHER: Unk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unk

14. Informant: L. B. Moon Coroner
(Address) Sandpoint, Idaho.

15. Filed Jan 20 1930. John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:

Homicide by Firearms.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. B. Moon Coroner, M. D.
Jan 20, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sandpoint, Idaho. | Date of Burial: Jan 21 1930.

20. Undertaker: Moon Mortuary | Address: Sandpoint Ida.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69083

PLACE OF DEATH
County of Bonner
City of Clarkesfork

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 1

(No.) 169
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Howard,

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L.A. Moon. Coroner.
(Address) Sandpoint Idaho.

15. Filed Jan 30 1930 John Larson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows
Suicide by Firearms.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L.A. Moon Coroner M. D.
Jan 30 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sandpoint, Idaho — Date of Burial Jan. 22 1930
20. Undertaker Moon Mortuary — Address Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69084

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185
(No. Priest River Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Infant of Mr. & Mrs. Earl Alford

206

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan. 1, 1930

7 AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Priest River Idaho.

PARENTS
10 NAME OF FATHER Earl Alford
11 BIRTHPLACE OF FATHER (city or town) (State or country) Bluff City Tenn.
12 MAIDEN NAME OF MOTHER Rosie Golden
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colville Wash

14 Informant Earl Alford
(Address) Priest River, Idaho.

15 Filed Jan 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 1, 1930 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to ....., 19...., that I last saw him alive on Jan 1, 1929 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Premature Birth

[signature] (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) R A Lowe, M. D.
Jan 1, 1930 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Woodmen Cemetery
Date of Burial: Jan. 1 1930

20. Undertaker: Earl Afford, Father
Address: Priest River, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69085

Local Registrar's No. 7

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. 410 Church st.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1012

2. FULL NAME Henry T Miller

(a) Residence. No. [illegible] St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Miller

6. DATE OF BIRTH (month, day and year): June 25 1845

7. AGE	Years	Months	Days	If LESS than 1 day, [illegible] hrs. or [illegible] min.
	84	7	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: David Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): [illegible]
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): [illegible]

14. Informant: Jane Miller
[illegible]: 410 Church st

15. Filed Feb. 3, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1929 to Jan 29, 1930
that I last saw him alive on Jan 29, 1930
and that death occurred, on the date stated above, at 9:20 P. m.
The CAUSE OF DEATH* was as follows:
(1) Pneumonia, Lobar. 3 das.
(2) Myocarditis, Chronic, Many years
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Starkpoole, M. D.
Jan 31, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fort Smith. Ark.	19
20. Undertaker: Cunnell Co	Address: Sandpoint

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69086

PLACE OF DEATH
County of Bonner.
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155.
Local Registrar's No. 6
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maggie Davis.

(a) Residence. No. 516 N. Ella Ave
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chas. E. Davis.

6. DATE OF BIRTH (month, day and year) March 15, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS
10. NAME OF FATHER Joseph Coulter.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Caroline Breese
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Chas E. Davis
(Address) Sandpoint Idaho

15. Filed Jan 30, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 28, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10, 1930, to January 28, 1930
that I last saw her alive on January 27th, 1930
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:

Influenza
(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) P. B. Evans, M. D.
1-29, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery — Date of Burial Jan. 30, 1930
20. Undertaker Moon Mortuary — Address Sandpoint Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69087

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hector Maertens

(a) Residence. No. No. 7 Milltown St.
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Elodie Maertens

6. DATE OF BIRTH (month, day and year): Sept. 15, 1882

7. AGE: Years 47 | Months 3 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Mill.
(c) Name of employer: Humbird Lbr. Co.

9. BIRTHPLACE (city or town) (State or country): Belgium

PARENTS

10. NAME OF FATHER: Petrus Maertens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Belgium
12. MAIDEN NAME OF MOTHER: Maria Tempelaere
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Belgium

14. Informant: Frank Maerten
(Address): Sandpoint Idaho.

15. Filed 1-25-, 1930 Floyd E. Kendall Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 1st, 1922, to January 20, 1930, that I last saw h~~im~~alive on January 20th, 1930 and that death occurred, on the date stated above, at 6:30 P~~M~~m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) F. B. Evans M. D.
1-22, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: Jan. 23, 1930

20. Undertaker: Moon Mortuary — Address: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69088

PLACE OF DEATH

County of Bonner

City of

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 4

(No. Humbird Lbr Co Camp 10 Bonner Co.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James E Arnell 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE about Years 65 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Humbird Lbr Co
(Address) Sandpoint Ida

15. Filed 1-25, 1930 Floyd G. Wendle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attended 19 to 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at 6:50 A m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
Diagnosis made from statement of D.D. Rich and Time keeper who found him dead
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Floyd G. Wendle, M. D.

Jan 21, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery — Date of Burial Jan 21 1930

20. Undertaker Turnbull Co — Address Sandpoint.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69089

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 18

Primary Registration District No. 2155

(No. #9 Milltown)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

88a

2. FULL NAME Mrs Oliva Nelson

(a) Residence. No. #9 Milltown St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 17 1858

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: unobtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: unobtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: A R Nelson
(Address) Sandpoint Ida

15. Filed 1-25, 1930 Floyd G. Wendle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Jan. 10, 1930 that I last saw her alive on Jan 9, 1930 and that death occurred, on the date stated above, at 10:20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and myocarditis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatic arthritis (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm F. Tyler, M. D.

Jan 11, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: 1/12 1930

20. Undertaker: Turnbull Co — Address: Sandpoint.

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69090

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159e

2. FULL NAME Infant Bradbury

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho.

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Katheryn Van Stone
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missoula Montana

14. Informant Mrs Van Stone
(Address) Hope, Idaho.

15. Filed 1-25, 1930 Floyd [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 7 (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 7, 1930.
that I last saw him alive on Jan 7th, 1930.
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Patent foramen ovale (Blue baby)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) O. F. Payne, M. D.
Jan 9, 1930. (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lincoln Cemetery | Date of Burial Jan. 10, 1930.

20. Undertaker Moon Mortuary | Address Sandpoint, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69091

Local Registrar's No. 1

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 16
Primary Registration District No. 2155
(No. Jefferson School)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John B Ries

(a) Residence. No. 911 W Cedar St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charlotte Ries

6. DATE OF BIRTH (month, day and year) Aug 30 1852

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) School house
(c) Name of employer

9. BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10. NAME OF FATHER Adam Ries
11. BIRTHPLACE OF FATHER (city or town) Unobtainable
(State or Country)
12. MAIDEN NAME OF MOTHER Unobtainable
13. BIRTHPLACE OF MOTHER (city or town) Unobtainable
(State or Country)

14. Informant Mrs Charlotte Ries
(Address) 911 W Cedar

15. Filed Jan 25, 1930 Floyd E Wessell
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 9:15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic [redacted] Myocarditis
heart disease

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterio Sc[redacted] rosis

(duration) 5 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? Previous Clinical
(Signed) Floyd E Wessell M. D.
1-7-30, 19... (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	1/8 1930
20. Undertaker	Address
Tunnell Co	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69092

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 13
Primary Registration District No. 21 0-0
Local Registrar's No. 3
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME Amelia A. Soderquist.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr A R. Soderquist

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 42 | Months 4 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lafayette Minn

PARENTS

10. NAME OF FATHER: Adolph Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.
12. MAIDEN NAME OF MOTHER: Anna.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Dr A R. Soderquist
(Address) Idaho Falls Idaho

15. Filed Feb 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 12, 1930
that I last saw her alive on Feb 12, 1930
and that death occurred, on the date stated above, at 6 30 A.m.
The CAUSE OF DEATH* was as follows:
Acute Intestinal Obstruction
(duration) yrs. mos. 2 1/2 ds.
CONTRIBUTORY (Secondary) Mesenteric Thrombosis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Yes Date of Feb 12-30
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
2/12, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 2/ 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69094

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 71-10
Primary Registration District No. 71
(No. 24)
Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Romona Barney

(a) Residence. No. ..... St. Camas, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 21, 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hamer Idaho

PARENTS

10. NAME OF FATHER Morni Barney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Elsinore Utah
12. MAIDEN NAME OF MOTHER Emma J. Carrigan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Malad, Idaho.

14. Informant Jack A. Wood.
(Address) Idaho Funeral Home

15. Filed Feb 17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from Feb 5, 1930, to Feb 5, 1930 that I last saw her alive on Feb 5, 1930 and that death occurred, on the date stated above, at 9-P. m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? In Camas, Idaho
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Elsinore Utah

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Feb 18 1930
20. Undertaker Jack A Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69095

Registration District No. 73

Primary Registration District No. 2150

Local Registrar's No. 28

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205 B

2. FULL NAME Arthur Grue

(a) Residence. No. 228 W. 14 St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	0	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs J. Johnson

(Address) Ogden Utah

15. Filed 2/6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Jan 30, 1930

that I last saw him alive on Jan. 30, 1930

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

Feb 6/1930 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Feb. 6 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69096

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V 50
Local Registrar's No. 27

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

65 B

2. FULL NAME Joseph Henry Flitton
(a) Residence No. 317 Basalt St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Stauffer

6. DATE OF BIRTH (month, day and year) July 21

7. AGE Years 52 Months 6 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Transferman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kaysville, Utah

PARENTS
10. NAME OF FATHER Albert Flitton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Nora Jane Hales
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City, Utah

14. Informant A. J. Flitton
(Address) Rigby Route #2

15. Filed 2/10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Feb 2, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 12-15 a m.
The CAUSE OF DEATH* was as follows:
Hodgkins Disease.
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hodgkins Disease
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Blood etc.
(Signed) [signature], M. D.
Feb. 6, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelton. Date of Burial Feb. 5 1930

20. Undertaker Jack A. Wood. Address Idaho Falls
J.C.S.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69097

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

504

2. FULL NAME David Brinson
(a) Residence. No. Willow Creek St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 18-1865

7. AGE: Years 64 | Months 9. | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER Thos Brinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Sarah A. Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant J. A. Ferrell
(Address) Idaho Falls Ida

15. Filed Oct 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:
Sudden Death
Cause Unknown
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Probably Embolism
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Dr. B. L. Allen M.D.
Feb. 6, 1930 (Address) Coroner Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: Feb 5 1930

20. Undertaker: V. F. McHan. | Address: Idaho Falls Ida.

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69098

PLACE OF DEATH

County of Bonneville. Registration District No. 23-

City of Idaho Falls. Primary Registration District No. 21V-0

Local Registrar's No. 20-

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth C Welmarth. #6

(a) Residence. No. 457 So. Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	married.

5a. If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Leander Welmarth

6. DATE OF BIRTH (month, day and year) Jan. 12-1856.

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	0	19.	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) St. Charles. Minn.

PARENTS

10. NAME OF FATHER Wm Petharam.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Emma Day.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mr Leander Welmarth
(Address) Idaho Falls. Ida.

15. Filed 2/13, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 24, 1927, to Jan. 28, 1930
that I last saw her alive on Jan. 31 1930
and that death occurred, on the date stated above, at 12.45 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of uterus -

positive (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Lacerations at child-birth -
about (duration) 30 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) Emma M. Gardner D.O. ~~M.D.~~
Feb 1, 1930 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wentworth L.D.	Feb 5 1930

20. Undertaker V. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69099

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

117

2. FULL NAME Carlson, Ingrid
(a) Residence. No. R#1, Pingree Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 1911

7. AGE: Years 18 Months 3 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Axel H. Carlson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Nanny Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant E. J. Peck
(Address) Blackfoot Idaho

15. Filed 1/31, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/30, 1930, to 1/31, 1930
that I last saw her alive on 1/31, 1930
and that death occurred, on the date stated above, at 12 30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Salpingitis and appendicitis, Surgical Shock.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1/31/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A. R. Sodenquist M. D.
1/31, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial Feb 1930

20. Undertaker E. J. Peck — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69101

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 214-0
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 22

2. FULL NAME Keith Taylor
(a) Residence. No. Blackfoot St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

24

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20, 1922

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot.

PARENTS
10. NAME OF FATHER Gilbert M Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salem Utah
12. MAIDEN NAME OF MOTHER Ella A Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montpelier Ida

14. Informant Delbert Taylor
(Address)

15. Filed 1/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Jan 28, 1930
that I last saw him alive on Jan 28, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Epidemic, Spinal Meningitis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Blackfoot Ida
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture
(Signed) [signature], M. D.
1/28, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot Idaho	Jan 30 1930

20. Undertaker Brown Eldredge Co Address Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69102

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 21
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johanna Rosdahl
(a) Residence. No. Idaho Falls, Idaho St. 164
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew L. Rosdahl
6. DATE OF BIRTH (month, day and year): July 8, 1851
7. AGE: Years 78 | Months 6 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Beata Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: C. W. Rosdahl
(Address) Central, Idaho
15. Filed Jan 29, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 28 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 3-10 p.m.
The CAUSE OF DEATH* was as follows:
Pneumonia
Senility
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) [illegible] M.D.
Jan 29, 1930 (Address) coroner Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Central, Idaho — Date of Burial: Jan 31 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69103

PLACE OF DEATH
County of Bannock
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

92

2. FULL NAME Henry Morgan Perry
(a) Residence. No. ..... St. Rigby Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or WIFE of): Fannie Young.

6. DATE OF BIRTH (month, day and year): Dec. 3, 1856

7. AGE: Years 73, Months 1, Days 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Utah.

PARENTS
10. NAME OF FATHER: Henry Elisha Perry.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Elizabeth Zobriskia.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: Mrs. H. M. Perry.
(Address): Rigby, Idaho.

15. Filed 1/28, 1930 (signature) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Jan 26, 1930
that I last saw him alive on Jan 25, 1930
and that death occurred, on the date stated above, at 12:30 a m.
The CAUSE OF DEATH* was as follows:
Thrombosis of Rt and left axillary arteries and Left femoral
(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rigby Idaho
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam.
(Signed) J. Forest, M. D.
Jan 26 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho.
Date of Burial: 1/28/30 19

20. Undertaker: A B Eckersell
Address: Rigby

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69105

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. FULL NAME Lula Althea Hansen

(a) Residence. No. 499 E. Street St. 156
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) February 7, 1916

7. AGE Years 13 Months 11 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Taylor Idaho

PARENTS
10. NAME OF FATHER Sidney L. Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington, Idaho
12. MAIDEN NAME OF MOTHER Nettie Lords
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Sidney L. Hansen
(Address) Taylor Idaho

15. Filed 1/25 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1930, to Jan 21, 1930
that I last saw her alive on Jan 30, 1930
and that death occurred, on the date stated above, at 8-15 p m.
The CAUSE OF DEATH* was as follows:
Staphylococci Pyemia
(duration) yrs. mos. 23 ds.
CONTRIBUTORY (Secondary) Metastatic abscesses of all parts of body
(duration) yrs. mos. 33 ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? 6 Date of Dec 26 to Jan 29
Was there an autopsy? no
What test confirmed diagnosis? Blood culture & abscess culture
(Signed) [signature], M. D.
1/22, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Taylor Idaho
Date of Burial Jan 25 1930
20. Undertaker Jack A. Wood
Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69106

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 21V-0
Local Registrar's No. 17

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161B

2. FULL NAME Baby Oate

(a) Residence. No. Ucon, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Yellow
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 14, 1930

7. AGE Years Months Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS
10. NAME OF FATHER Joe Oate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Harkko Harada
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ammon Idaho

14. Informant Joe Oate
(Address) Ucon, Idaho

15. Filed 1/21, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 16, 1930
that I last saw her alive on Jan 16, 1930
and that death occurred, on the date stated above, at 3-30 a m.
The CAUSE OF DEATH* was as follows:
Breech Delivery Some Brain injury
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
Jan 16, 1930 (Address) Ida Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Idaho Date of Burial Jan 20 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69107

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 7301
(No. 770 S. 1st Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

1013

2. FULL NAME Mary M. Peterson

(a) Residence. No. Goshen, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 21 1928

7. AGE: Years 1 | Months 5 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Goshen, Idaho

PARENTS

10. NAME OF FATHER: William P. Petersen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Veda Monson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Syracuse Utah

14. Informant: William P. Peterson
(Address) Goshen, Idaho

15. Filed Jan 1st, 1930 Clement Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-13, 1930, to 1-15, 1930, that I last saw h[illegible] alive on 1-14, 1930 and that death occurred, on the date stated above, at 3-40 P m.

The CAUSE OF DEATH* was as follows:
aspiration Pneumonia
Right Lung.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) aspirated a glass bead.
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of
Was there an autopsy? yes.
What test confirmed diagnosis? gross findings
(Signed) Edwin Cutler, M. D.
1-16-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Goshen, Idaho — Date of Burial: Jan 19 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69108

PLACE OF DEATH.
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 N-0
(No. L.O.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14 —

2. FULL NAME Anna Jane Heaton 24

(a) Residence. No. Ririe, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas Heaton

6. DATE OF BIRTH (month, day and year) Nov 23, 1883

7. AGE Years 46 Months 2 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portage, Utah

PARENTS
10. NAME OF FATHER Enoch Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Portage, Utah
12. MAIDEN NAME OF MOTHER Jane Haskin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Grace Heaton
(Address) Idaho Falls, Idaho

15. Filed 1/18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1930, to Jan 16, 1930
that I last saw her alive on Jan 16, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH was as follows:
Ep. Spinal Meningitis
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) hospital 5 minutes before death.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Riri
Did an operation precede death? no Date of
Was there an autopsy? no (Spinal puncture after death)
What test confirmed diagnosis? same
(Signed) [signature], M. D.
1/18, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ririe, Idaho Date of Burial Jan 19 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69109

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 14

(No.) 205 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza S. Haycock
(a) Residence. No. Iona, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 16, 1848

7. AGE: Years 80, Months 8, Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: John Stredder
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elizabeth Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Elizabeth Frandsen
(Address) Iona, Idaho

15. Filed Jan 17, 1930 Wm Kimmard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:

No medical attendance
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm Kimmard, M. D.
1/17, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho
Date of Burial: Jan 17 1930

20. Undertaker: Jack A. Wood
Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69111

PLACE OF DEATH

County of Bonneville, Registration District No. 13

City of Idaho Falls, Primary Registration District No. 2170 Local Registrar's No. 12

(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Homer L. Maddock. 1010a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 11 1930

7. AGE: Years 8 | Months 3 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls.

PARENTS

10. NAME OF FATHER: Joe Maddock.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): East Jordon Michigan.
12. MAIDEN NAME OF MOTHER: Bernetta Green.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nassau, Miss.

14. Informant: Mr Joe Maddock.
(Address): Idaho Falls. Ida.

15. Filed Jan 14, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec., 1929, to Jan 11 1930
that I last saw h[illegible] alive on Jan 11, 1930
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Lobar pneumonia + Bacteremia
(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? home Idaho Falls
Did an operation precede death? no Date of
Was there an autopsy? No only X-ray + aspiration
What test confirmed diagnosis? See above + Lab.

(Signed) J. P. [illegible], M. D.
1/11, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 1/15 1930

20. Undertaker: [illegible] F. McHan | Address: Idaho Falls Ida.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69112

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 11
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Rula Phillips
(a) Residence No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) August 8, 1929
7. AGE Years Months 5 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS
10. NAME OF FATHER John H. Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston, Idaho
12. MAIDEN NAME OF MOTHER Lavina Minnie Andrus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. ~~Informant~~ address Ucon, Idaho
~~(Address)~~ Informant, John H. Phillips
15. Filed Jan 15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 14 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930 to Jan 14, 1930
that I last saw her alive on Jan 14, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Ucon
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual Diagnostic
(Signed) [signature] M. D.
1/14, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ucon, Idaho
Date of Burial Jan 15 1930
20. Undertaker Jack A. Wood
Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69113

Registration District No. 73
Primary Registration District No. 210
Local Registrar's No. 18

1884

PLACE OF DEATH

County of Bonneville
City of Idaho Falls.
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Oliver McBride
(a) Residence. No. Moreland - Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth McBride

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Oliver Stephen McBride
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eng
12. MAIDEN NAME OF MOTHER Elmira Callaheer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Virgil McBride
(Address) Idaho Falls

15. Filed 1/14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 12. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 3-48 p.m.
The CAUSE OF DEATH* was as follows: By being struck by an automobile driven by Doyle M. Cathcart, said accident being unavoidable.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O. B. Gallion M.D.
Jan 14, 1930 (Address) Coroner Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot, Idaho	Jan 15 1930

20. Undertaker Jack G. Wood Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69114

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 3
Primary Registration District No. 2 1 4 0
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 9 24

2. FULL NAME Dora M. Williams
(a) Residence. No. Blackfoot R 7 S. St. Blackfoot
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George R Williams

6. DATE OF BIRTH (month, day and year) Jan 30. 1878

7. AGE	Years	Months	Days	If LESS than 1 day,
	51	11	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS

10. NAME OF FATHER O. F. Murdock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Celestia Sadoro
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant John R Williams
(Address) Blackfoot

15. Filed Jan 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 11, 1930
that I last saw h[illegible] alive on Jan 11, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Epidemic Meningitis
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot, Ida
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) H. Kunz Hatch, M. D.
Jan 12, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~ Cremation, or Removal: Blackfoot — Date of Burial: Jan 14 1930
20. Undertaker: Jack A. Hood — Address: Idaho Falls

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69115

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 72
Primary Registration District No. 2197
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

24

2. FULL NAME Clay Stolworthy

(a) Residence. No. 340 - J St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 24, 1914

7. AGE — Years: 5 | Months: 2 | Days: 15 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelley, Idaho

PARENTS

10. NAME OF FATHER: E. A. Stolworthy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Ora Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: E. A. Stolworthy
(Address) Idaho Falls, Idaho

15. Filed Jan 11, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 11 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 11, 1930
that I last saw him alive on Jan 10, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

17 hrs
(duration) ____ yrs. ____ mos. ____

CONTRIBUTORY
(Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
____, 19____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Jan 2 1930

20. Undertaker: Jack G. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69116

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 1 4 0

Local Registrar's No. 7

(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Melvina McInelly

(a) Residence. No. Shelley, Idaho Route 1 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 28, 1914

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
15	7	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School-girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Esclante, Utah

PARENTS

10. NAME OF FATHER Ezra McInelly

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elsie Collins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Marysville, Utah

14. Informant Mrs. Ezra McInelly
(Address) Route 1 Shelley, Idaho

15. Filed 1/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-4, 1930, to 1-7, 1930

that I last saw her alive on 1-7-, 1930

and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Measles.

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin Cutler M. D.

1-8-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley Cemetery

Date of Burial: 1-8 1930

20. Undertaker: Jack A. Wood

Address: Idaho Falls Idaho

RECEIVED FEB 17 1930

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69117

Registration District No.

Primary Registration District No.

Local Registrar's No. 6

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

149

2. FULL NAME Hannah Larsen Keller

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: N

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Sylvester Keller

6. DATE OF BIRTH (month, day and year) Dec 21-1888

7. AGE Years: 42 Months: x Days: 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mincreek Utah

PARENTS

10. NAME OF FATHER Peter Larsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Sylvester Keller

(Address) Rigby Route #2

15. Filed 1/30, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 28 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to Jan. 8, 1930 that I last saw her alive on Jan 8, 1930 and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows: Toxaemia of pregnancy and confinement

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + laboratory

(Signed) H Ray Hatch M. D.

Jan 8, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Milo Cem. Date of Burial: Jan 12 1930

20. Undertaker: Vern J. Keller Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

[illegible] RESERVED FOR BINDING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69118

PLACE OF DEATH
County of Bonneville
City of Ammon

Registration District No. 73
Primary Registration District No. 21V-0

Local Registrar's No. 1

(No. 101 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Sato

(a) Residence. No. Ammon, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Yellow	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 29, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ammon, Idaho

PARENTS

10. NAME OF FATHER Joe. S. Sato
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Haru Sato
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant J. S. Sato
(Address) Ammon, Idaho

15. Filed 1/7, 1930 C[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Jan. 5, 1930
that I last saw her alive on Dec. 29, 1929
and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:
Inspiration Pneumonia
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Breech Delivery
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. K. Williams M. D.
Jan. 6, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Rose Hill Idaho Falls	Jan. 6 1930
20. Undertaker	Address
Jack G. Hood	Idaho Falls

RECEIVED FEB 17 1930

PLACE OF DEATH

County of .....

City of .....

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69119

Registration District No. 73

Primary Registration District No. 21V-0

Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William J. Stoddart 44

(a) Residence. No. Fort Hall, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Stoddart

6. DATE OF BIRTH (month, day and year) March 4, 1861

7. AGE Years 69 Months 10 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lehi, Utah

PARENTS

10. NAME OF FATHER William Stoddart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Margaret Alpin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Jos. Stoddart
(Address) Fort Hall, Idaho

15. Filed 1/7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Dec. 28, 1929

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature] Jan 6, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Firth, Idaho Date of Burial Jan 7 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69120

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2140

Local Registrar's No. 3

(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joy Maxine Metcalf

(a) Residence. No. Iona Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

116

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 29-1929

7. AGE Years 0 Months 9 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER W. H. Metcalf

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho Falls Ida.

12. MAIDEN NAME OF MOTHER Ruby Helm

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls

14. Informant W. H. Metcalf
(Address) Iona Idaho

15. Filed Jan 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1929, to Jan 6, 1930
that I last saw her alive on Jan 5, 1930
and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Iona Idaho

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical cause

(Signed) [signature], M. D.

Jan 7, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona Idaho — Date of Burial: Jan 8 1930

20. Undertaker: V. F. McHan — Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 17 1930

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2 10 0

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69121

Local Registrar's No. 2

48 B

2. FULL NAME Juanita Johnson Reed

(a) Residence. No. 287 - 6th St.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Charles S. Reed

6. DATE OF BIRTH (month, day and year) July 22, 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	5	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peoria, Illinois

PARENTS

10. NAME OF FATHER John Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Peoria, Illinois

12. MAIDEN NAME OF MOTHER Sarah Whittington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Peoria Illinois

14. Informant J. E. Johnson

(Address) Cozad, Nebraska

15. Filed Jan 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to Jan 1, 1929

that I last saw h[er] alive on Jan 1, 1929

and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) 7 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Goiter

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~~No~~

Did an operation precede death? No Date of

Was there an autopsy? Clinical

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/7, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rose Hill - Idaho Falls	Jan. 5 1929
20. Undertaker	**Address**
Jack A. Wood	Idaho Falls, Idaho

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69122

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

131

2. FULL NAME Andrus Gustaf Lofgren
(a) Residence. No. 675 - North Water Ave. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Johanna Lofgren

6. DATE OF BIRTH (month, day and year) Oct. 29, 1849

7. AGE: Years 80 | Months 2 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: ? - Lofgren
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Kathyrn Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Gustaf Lofgren
(Address) Shelley, Idaho

15. Filed 1/3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 19.. to Jan 3, 1930
that I last saw him alive on Jan 2, 1929
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Uremic Poisoning from prostatic obstruction.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Senility - Prostatic Cystitis - Hypertrophy.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
1/3, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Hill - Idaho Falls | Date of Burial: Jan. 5 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69123

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
(No. 122)
Local Registrar's No. 16
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mc Henry

(a) Residence. No. Arco, (Usual place of abode) Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Ellender Mc Henry

6. DATE OF BIRTH (month, day and year) 1855, Dec. 5

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER William Mc Henry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Millie Elrod
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tennessee

14. Informant O J Mc Henry
(Address) Arco, Idaho

15. Filed Jan. 17, 1930 W. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1929, to Dec. 26, 1929
that I last saw him alive on Dec 26, 1929
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Examination

(Signed) S. R. Eckert, M. D.
Jan 17, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco, Idaho	Jan. 18 1930

20. Undertaker Chas. R. Garner Address Arco, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69124

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Beth Duke

(a) Residence. No. Arco, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE wt
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Jan. 13 - 1930

7. AGE Years | Months | Days | If LESS than 1 day, 11 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Arco, Idaho

PARENTS
10. NAME OF FATHER Leo Duke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Santaquin, Utah
12. MAIDEN NAME OF MOTHER Nellie Coombs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Thatcher, Idaho

14. Informant Leo Duke
(Address) Arco, Idaho.

15. Filed Jan. 14, 1930 T. C. Balt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Jan 13, 1930
that I last saw her alive on Jan 13, 1930
and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
(duration) 11 hours yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? Physical examination
(Signed) I. N. Egbert M. D.
Jan 14, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Arco Idaho | Date of Burial Jan. 14 1930

20. Undertaker Theo R. Garnier | Address Arco, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69127

PLACE OF DEATH
County of Canas
City of Fairfield Ida
Registration District No. 58
Primary Registration District No. 2138
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 1896

2. FULL NAME Reuben D. Miller

(a) Residence. No. Fairfield Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug. 14-1908

7 AGE: Years 21 | Months 4 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) R. builder O.S.L.R.R.
(c) Name of employer O.S.L.R.R.

9 BIRTHPLACE (city or town) (State or country) Porral Ida.

PARENTS
10 NAME OF FATHER Dee Miller
11 BIRTHPLACE OF FATHER (city or town) (State or country) Central City, Nebr.
12 MAIDEN NAME OF MOTHER Millie Kootutz
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Auburn Iowa

14 Informant Dee Miller
(Address) Porral Ida.

15 Filed Jan. 4 1930 Minnie Perkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 4 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1929, to Jan. 4, 1930, that I last saw him alive on Jan. 4. 1930, and that death occurred, on the date stated above, at 2-25 P.M.

The CAUSE OF DEATH* was as follows:
Automobile accident resulting in dislocation of 4th 5th & 6th Cervical Vertebrae & paralysis from shoulders down.
(duration) yrs. 3 mos. 27 ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) W. B. Sheets M. D.
Jan. 4. 1930 (Address) Fairfield Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 7 1930
20. Undertaker: Summers & Kirke — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC... FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69128

PLACE OF DEATH
County of Canyon
City of Wilder (Fargo)

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Cyprusia Faris Gilbert

(a) Residence. No. Wilder Rt 1 St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Anna Gilbert

6. DATE OF BIRTH (month, day and year) July 27- 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	6	20	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Bath New York

PARENTS
10. NAME OF FATHER H. Gilbert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Ernest D. Gilbert
(Address) .....

15. Filed 1-19-, 1930. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan - 17- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Jan 17, 1930
that I last saw ~~him~~ alive on Jan 16, 1930
and that death occurred, on the date stated above, at 10:00 A m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Chronic Endocarditis
(duration) 2 yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Lab.
(Signed) Robert E Talbot, M. D.
Jan 20, 1930 (Address) Wilder

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	1-19- 1930

20. Undertaker	Address
C. L. Peckham	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69131

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joyce Adell Shaffer

100a

(a) Residence. No. 303 Blaine St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-7-1924

7. AGE: Years 5, Months 11, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Long Beach, Calif

PARENTS

10. NAME OF FATHER: F. John Shaffer

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Caldwell

12. MAIDEN NAME OF MOTHER: Della Shelton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St Pearl Idaho

14. Informant (Address): Mrs F M Shelton

15. Filed 1-26-, 1930- John S. Meyer- Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan- (Month) 23- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to Jan. 23, 1930 that I last saw her alive on Jan 22, 1930 and that death occurred, on the date stated above, at 12:15 [illegible]

The CAUSE OF DEATH* was as follows: Broncho Pneumonia and Peritonitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Influenza.

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? McDermott Nev.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) David E Baird, M. D.

Jan. 24, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cemetery — Date of Burial: Jan-26- 1930

20. Undertaker: C. V. Peckham — Address: Caldwell Idaho

By W. E. Foster

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69132

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 10

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Siebenberg

(a) Residence. No. Caldwell R#1 St. 48 a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida May Siebenberg

6. DATE OF BIRTH (month, day and year): Aug-12-1855

7. AGE: Years 74, Months 5, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Cassel Germany

PARENTS

10. NAME OF FATHER: Henry Siebenberg

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cassel Germany

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: .....
(Address) Walter Siebenberg

15. Filed 1-27-, 1930- John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan- (Month) 25- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1926, to Jan 25, 1930

that I last saw him alive on Jan 20, 1930

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Endocarditis and
[illegible]

..... (duration) 4 yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.

1/27, 1930 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: Jan-28- 1930

20. Undertaker: C. V. Peckham by W.E.T.

Address: Caldwell Idaho

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69133

PLACE OF DEATH
County of Canyon
City of Caldwell.

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 11
(No. Caldwell Route #1.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Mrs. Anna R. Culver.
(a) Residence. No. Boise, Idaho. Collister Station.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19th 1857

7. AGE Years 72 Months 8 Days 9 If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield, Ill.

PARENTS
10. NAME OF FATHER E. E. Rogers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Mary Dericksen.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant (Address) Pearl Allen. Boise, Idaho.

15. Filed 1-29, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 28th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 15, 1927, to Jan 27, 1930
that I last saw her alive on Jan 27, 1930
and that death occurred, on the date stated above, at 9:45 A.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phy Exam & Laboratory
(Signed) Alfred Budge Jr., M. D.
Jan 29, 1930 (Address) Boise Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 1/30/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69134

Local Registrar's No. 12

174

2. FULL NAME Glenn Allen Wilson

(a) Residence. No. R F D No. 2 - St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 30-29

7. AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
- *	- -	30	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER W W Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davenport Wash

12. MAIDEN NAME OF MOTHER Ruby Blakley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dorchester Nebr

14. Informant Mrs W W Wilson

(Address) Caldwell Idaho

15. Filed 1-29-, 19 30 John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 28-30 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Burned to death. Accidental.
Residence burned to ground.
No inquest.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Paul L. Case, Coroner, M. D.

Jan 28-30 19..... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Jan 29-30 19
20. Undertaker	**Address**
Paul L. Case	Caldwell Idaho

Dup

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69135

Local Registrar's No. 13

2. FULL NAME Cordelia Irene Hopkins

(a) Residence. No. Parma Idaho St. 75

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 6

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
24	5	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gotebo Oklahoma

PARENTS

10. NAME OF FATHER H. G. Church

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Quincey Ill.

12. MAIDEN NAME OF MOTHER Ollie Hatchley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cleveland Tenn

14. Informant W V Hopkins.

(Address) Parma Ida R# 3

15. Filed 2-7-, 1930 John S. Meyer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Feb 1, 1930 that I last saw her alive on Feb 1, 1930 and that death occurred, on the date stated above, at 4:57 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ascending Paralysis (Landry's)

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Focal infection - Jaw

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? X

Did an operation precede death? Extraction Date of Jan 26 - 30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S B Linsley M. D.

Feb 3, 1930 (Address) Caldwell, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma, Idaho.	Feb - 3 - 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

Canyon

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69136

PLACE OF DEATH

County of Canyon
City of Middleton Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 14

(No.) 460
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ellen Moore

(a) Residence. No. / Middleton Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of A. W. Moore

6. DATE OF BIRTH (month, day and year) May 5 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	8	26	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mechanicsburg Iowa

PARENTS

10. NAME OF FATHER James R. Lent

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelby Co. Indiana

12. MAIDEN NAME OF MOTHER Sarah J. Whited

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs. Effie J. Stillwell
(Address) Middleton Ida.

15. Filed 2-7-, 1930. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31, 1930, to Feb 2, 1930
that I last saw h~~e~~s alive on Feb 2, 1930
and that death occurred, on the date stated above, at 6-20 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bob Russell M. D.

Feb 7, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Middleton Cem	2-5-1930

20. Undertaker J. V. Peckham Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69137

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Mrs. Sallie Frazier

(a) Residence. No. Cleveland Blvd #704
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of James A. Frazier

6. DATE OF BIRTH (month, day and year) May 22 1848

7. AGE: Years 81, Months 8, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Chas Co. Missouri.

PARENTS

10. NAME OF FATHER Stuart A. Hall.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Zerelda Darst.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Orville R. Ackley
(Address) 306 West Center St. Anaheim Cal.

15. Filed 2-7-1930. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1923, to Feb 3, 1930
that I last saw her alive on Feb 3, 1930
and that death occurred, on the date stated above, at 8-15 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Old age & Mediastinal Fistula 5
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) S. B. Dudley, M. D.
Feb 5, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 2-7 1930

20. Undertaker: C. V. Peckham. Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69138

PLACE OF DEATH
County of Canyon
City of Notus

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

74a

2. FULL NAME John M. Demo
(a) Residence. No. Notus Ida #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Emma Demo

6. DATE OF BIRTH (month, day and year) Mch-20-1866

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	10	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) National Iowa

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant S. E. Tucker
(Address) Notus Ida

15. Filed 2-7-, 1930. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Feb 5, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12-30 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (duration) ..... yrs. ..... mos. Sudden ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
2/6, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 2/7- 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

PLACE OF DEATH

County of Canyon

City of Wilder

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 3

Registration District No.

Primary Registration District No. 2005

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69139

Local Registrar's No. 17

1614

2. FULL NAME Marvin Edward Evans 3

(a) Residence. No. R 1 Wilder Idaho 2005 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 7 1930

7. AGE Years	Months	Days	If LESS than 1 day,
- -	- -	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER Walter E. Evans

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Avon Idaho

12. MAIDEN NAME OF MOTHER Maud Powell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Georgia

14. Informant Walter E.Evans

(Address) Wilder Idaho

15. Filed 2-10-, 1930 - John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 9 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th 1930, to Feb 9, 1930

that I last saw h— alive on Feb 9, 1930

and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? history

(Signed) W. Montgomery, M. D.

2/10, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder Cemetery	Feb 10-30 19

20. Undertaker	Address
Paul L.Case	Caldwell Idaho

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69140

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 18
(No. 181B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mannie E. Bedford
(a) Residence. No. 506 Dearborn St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Had been an invalid
(b) General nature of industry, business, or establishment in which employed (or employer): for several years
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Harris Kentucky

PARENTS

10. NAME OF FATHER: Jacob Jacoby
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs S. Ben Dunlap
(Address): 502 Dearborn

15. Filed 2-10-, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Feb 9, 1930
that I last saw h[illegible] alive on Feb 9, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows: Hy postatic Pneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary): Paralysis -
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) T. D. Farmer M. D.
Feb 10, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb 11 1930
20. Undertaker	Address
Paul L. Case	Caldwell, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69141

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

100a

2. FULL NAME Harriet Persis Babcock

(a) Residence. No. ..... St. Spanish Fork, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 22nd 1852

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77	10	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): not known

PARENTS

10. NAME OF FATHER: Thomas McKee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: Persis Sweat
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known

14. Informant: Mrs. Hyrum Babcock
(Address) Nampa, Idaho

15. Filed 1-6, 1929 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Jan. 5, 1930
that I last saw her alive on Jan. 4, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible] M. D.
Jan. 6, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spanish Fork, Utah
Date of ~~Burial~~ Shipment: 1-6 1930

20. Undertaker: Mrs. Nina M. Valley
Address: Nampa, Ida.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69143

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1056
Local Registrar's No. 3
(No. 812 - 2nd St. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Umphrey D. Kindred
(a) Residence. No. 812 - 2nd St. So. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of M. J. Kindred

6. DATE OF BIRTH (month, day and year) June 22nd 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lexington
(State or country) Kentucky

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Mrs. M. J. Kindred
(Address) Nampa, Idaho

15. Filed 1-7, 1930 Leetha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Jan 6, 1930.
that I last saw h.. alive on Jan 6, 1930
and that death occurred, on the date stated above, at 3 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremic poisoning.
(duration) yrs. mos. 1C ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C C Reeling M. D.
1-7, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Meridian, Idaho — Date of Burial: Jan. 8th 1930
20. Undertaker: Wm F. Talley — Address: Nampa, Ida.

Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69144

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 1012 - 10 ave S)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

90

2. FULL NAME William Patterson Cornwell

(a) Residence. No. 1012 - 10 ave S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10-28-60

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Willis Cornwall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER ~~Carol~~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs W. P. Cornwell
(Address) Nampa Ida

15. Filed 1-10, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 5, 1930
that I last saw him alive on Jan. 5, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Decomposition of old injured Cerebro-Mental Concussion (duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Ted R. Proctor M. D.
Jan. 10, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	1-8 1930
20. Undertaker	Address
F. K. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69145

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

101a

2. FULL NAME Patrick John Foley
(a) Residence. No. 7-Mile E of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 2-1870

7. AGE 59 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Ill

PARENTS
10. NAME OF FATHER Pat Foley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Carol
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs P. J. Foley
(Address) Kuna, Ida

15. Filed 1-9, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Jan 7, 1930
that I last saw him alive on Jan 6, 1930
and that death occurred, on the date stated above, at 2 AM m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) Samuel A Swayne, M. D.
1-10, 1930 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlertown Cem Kuna Ida — Date of Burial 1-9 1930

20. Undertaker Fred K. Robinson — Address Nampa Ida

5

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69146

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006
(No. 1424 - 1st St. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

65a

2. FULL NAME Hattie Bell
(a) Residence. No. 1424 - 1st St. No. St. Sidney, Nebr.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 1 mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bennett Bell

6. DATE OF BIRTH (month, day and year) Jan. 20th 1874

7. AGE: Years 55, Months 11, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) Mr. Glenn Bell Nampa Ida.

15. Filed Jan 8th, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to Jan 8, 1930
that I last saw her alive on Jan 7, 1930
and that death occurred, on the date stated above, at 5 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lymphoid Leukemia

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Neb
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) V. C. Beckman M. D.
1-8-, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Sydney, Nebraska. Date of ~~Burial~~ Shipment 1-9 1930

20. Undertaker: Wm. D. Talley Address Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69147

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

49

2. FULL NAME J. A. Mc Robbie

(a) Residence. No. 416 8th Ave S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 7-25-1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Thos Mc Robbie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Janet Ernston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs Geo. Karcher
(Address) Nampa Ida Ave S

15. Filed 1-9, 1930 Della Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 7, 1930
that I last saw him alive on Jan 5, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis and
Myocarditis (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace B Bellknap M. D.
Jan 9, 1930 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	1-10 1930
20. Undertaker	**Address**
L. K. Robinson	Nampa Ida

H.P.B.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69148

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 8
(No. Murray Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Abraham Paulson 100a

(a) Residence. No. Rural St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	-	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant O M Ranton
(Address) Huston Idaho

15. Filed 1-10, 1930 Hetta Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929 to Jan 6, 1930
that I last saw him alive on Jan 6, 1930
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. H. Murray, M. D.
Jan 10, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	1-10 1930
20. Undertaker	Address
L. K. Robinson	Nampa Ida

Murray

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69149

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospt)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

111 B

2. FULL NAME George Hartman
(a) Residence. No. 2 Miles North St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes Hartman

6. DATE OF BIRTH (month, day and year) April 27 - 1864

7. AGE: Years 65, Months 8, Days 19. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa City Iowa

PARENTS

10. NAME OF FATHER: Geo. Hartman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Bergadine Long
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Agnes Hartman
(Address) Nampa R#2

15. Filed 1-11, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Jan 9, 1930
that I last saw him alive on Jan 9, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
acute Hemorrhage from duodenal ulcer
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. P. Ross, M. D.
Jan 10, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Denver Colo
Date of Burial: 1-11 1930

20. Undertaker: Fred K Robinson
Address: Nampa Ida.

R

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69150

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 7056
(No. 44)
Local Registrar's No. 10

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Henry Duey

(a) Residence. No. 1416 1st St S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3-1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Prop. of Rooming House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs Dora Duey
(Address) Nampa Ida

15. Filed 1-13, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Jan 12, 1930
that I last saw him alive on Jan 12, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Acute Haemorrhage Brain

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Influenza & nephritis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Here.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace B Belknap M. D.
1-13, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal	Date of Burial 19
Sheridan Wyo	
20. Undertaker D. K. Robuson	Address Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69151

PLACE OF DEATH
County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2886
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Susan A. Hennessey 100a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21 - 1852

7. AGE 78 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant W. H. Hennessey
(Address) Meridian #3, Ida

15. Filed 1-13, 1930 Leitha Conway Registrar
Coleman

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ Dec 26, 1930, to ~~Dec~~ Jan 8, 1930
that I last saw her alive on Jan Jan-8, 1930
and that death occurred, on the date stated above, at 6 00 A m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

..... (duration) ..... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? — — —

Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) F J Coleman M. D.
Jan 13, 1930 (Address) Kuna, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kuna, Ida | Date of Burial 1-13 30

20. Undertaker L. K. Robinson | Address Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69152

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

2. FULL NAME Robert Lee Summers

(a) Residence. No. 212 - 12 ave N St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —
6. DATE OF BIRTH (month, day and year): Mar 23 - 1918
7. AGE: Years 11, Months 10, Days, If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): West Virginia

PARENTS

10. NAME OF FATHER: J. C. Summers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): West Virginia
12. MAIDEN NAME OF MOTHER: Grace Wills
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska

14. Informant: J. C. Summers
(Address) 212 - 12 ave No Nampa Idaho

15. Filed 2-9, 1930 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1930, to Jan 26, 1930
that I last saw him alive on Jan 25, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Acute dilatation heart
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Myocarditis & Rt heart dilated. (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace Bellknap, M. D.
1-27, 1930 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem
Date of Burial: 1-29 1930

20. Undertaker: F. K. Robinson
Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

B

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69153

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 14
(No. 2½ mi east Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101A

2. FULL NAME Virginia Mary Mayne

(a) Residence. No. 2½ mi. east nampa St.
(Usual place of abode.)
Length of residence in city or town where death occured 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Geo. W. Mayne

6. DATE OF BIRTH (month, day and year) July 11th 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Felix Amoureaux
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary Boyington
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) Geo. Mayne Nampa Ida

15. Filed 1-20, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Jan 17, 1930
that I last saw her alive on Jan 17, 1930
and that death occurred, on the date stated above, at 1:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
preceded by Bronchopneumonia
(duration) ....yrs. ....mos. 24 ds.
CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Murray, M. D.
Jan 18, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Mt. Calvary, Nampa. Date of Burial: 1-20 1930
20. Undertaker: Mrs. Nina M. Talley Address: Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69154

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 15
(No. 18th + 3rd st. no.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia A White
(a) Residence. No. 18th + 3rd St. north St.
(Usual place of abode.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob A. White

6. DATE OF BIRTH (month, day and year) March 30th 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rockport Missouri

PARENTS

10. NAME OF FATHER Jeremiah Barlow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Mr Forest White Nampa, Idaho

15. Filed 1-30, 1930 Estella Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jan. (Day) 27 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1929, to Jan 27, 1930
that I last saw h.. alive on Jan 27, 1930
and that death occurred, on the date stated above, at 5:38 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis
Edema of Lungs
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. 16 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel A Swayne M. D.
Jan 28, 1930 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 1 30 1930
20. Undertaker: Mrs. Nina M. Talley Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69155

PLACE OF DEATH
County of Canyon
City of Middleton
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 1
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Theodosia Smith.

(a) Residence. No. Middleton St. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of James L. Smith

6. DATE OF BIRTH (month, day and year) June 9-1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	6	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indy

PARENTS

10. NAME OF FATHER W. A. George

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kent, Ionia

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. W. B. Church
(Address) Boise Ida

15. Filed 1-3-, 1930 John S. Meyers. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 1, 1930
that I last saw h~~er~~ alive on Jan 1-, 1930
and that death occurred, on the date stated above, at 9-30 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris —
Sudden death —

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) T. D. Frazer M. D.
Jan 2nd, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	1/2 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69156

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 2

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Lillian Hautence De Lyria
(a) Residence. No. Logan St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ E. T. De Lyria

6. DATE OF BIRTH (month, day and year) Dec. 31 - 1861

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	—	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kalamazoo Mich.

PARENTS

10. NAME OF FATHER Wesley McNiach
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. D. F. De Cummit
(Address) Caldwell Ida

15. Filed 1-13, 1930. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1925 to Jan 9, 1930
that I last saw her alive on Jan 9, 1930
and that death occurred, on the date stated above, at 2-45 P m.
The CAUSE OF DEATH* was as follows: Myocarditis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Chr. Arthritis deformans
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Kelley, M. D.
1-10, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 1-13 1930

20. Undertaker: E. V. Peckham
Address: Caldwell Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 11 1930

PLACE OF DEATH

County of Canyon

City of Caldwell R# 3

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69157

Local Registrar's No. 3

113

2. FULL NAME Carl Barnes Hamilton

(a) Residence. No. Caldwell R# 3 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Forrest Hamilton

6. DATE OF BIRTH (month, day and year) Oct- 15- 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	2	29	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER A. Taylor Hamilton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER E.J. Barnes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Mrs Carl Hamilton

(Address)

15. Filed 1-15-, 1930 John S. Meyer- Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan- 13- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 4., 1930, to Jan 13., 1930
that I last saw h~~im~~ alive on Jan 12., 1930
and that death occurred, on the date stated above, at 8:20 A.m.
The CAUSE OF DEATH* was as follows:

Meningeal Influenza

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza Pneumonia

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David E Baird, M. D.

Jan 13., 1930 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasant Ridge Cem	1-15- 1930
20. Undertaker	Address
C.A. Peckham-	Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 11 1930

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69158

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 4

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME MrsMary M. Fitts

(a) Residence. No. Ten Davis District St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. A. Fitts

6. DATE OF BIRTH (month, day and year) Nov 16, 1869

7. AGE: 60 Years | Months: 1 | Days: 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER D. C. Wells

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Carpenter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Massachussetts

14. Informant J. A. Fitts
(Address) Notus Idaho

15. Filed 1-16-, 1930- John S. Meyes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan-14 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 14, 1930 that I last saw her alive on Jan 14, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Pneumonia - lobar with cerebral & spinal involvement

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscope & stethoscope

(Signed) [signature] M. D.

1/15, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ten Davis Cemetery | Date of Burial: 1-16-30 19

20. Undertaker: Paul L. Case | Address: Caldwell Ida

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69159

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Martin Hecimovich HECIMOVICH 41
(a) Residence. No. Bank Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Do not know
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant E. D. Whiteman Stone
(Address) Soda Springs Ida
15. Filed 1-29, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jany (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to June 28, 1930
that I last saw her alive on June 28, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Infelicis of leg - caused by old trauma - gangrene developed - 3 amputations -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Dec
Was there an autopsy? 0
What test confirmed diagnosis? —
(Signed) Elias Kaczky, M. D.
1/30/, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Soda Springs — Date of Burial 1-30 1930
20. Undertaker E. D. Whiteman — Address Soda Springs

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP'8 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69159

Dr. Ellis Kackley
Soda Springs, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Martin Hecimovich who died at Soda Springs, Idaho on Jan. 28, 1930
Cause of death given as "infection of leg."

Information DESIRED in order to complete certificate:

please state the cause of the infection. Due to injury? If so, was it a mining accident? Will you please give us an approximate age for this man?

PLEASE ANSWER BELOW:

Caused by an old trauma, necrosis of 3rd Met. Tar. first, then of t the ankle, amputation of foot, gangreen developed, two subsequent amputations, soft parts kept on sloughing, died from the infection.

Ellis Kackley

RECEIVED FEB 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69160

PLACE OF DEATH
County of Canbury
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Donald Wayne Ellis
(a) Residence. No. Soda Springs Idaho St. — 71B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Baby
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Nov. 13-29-
7. AGE Years 0 Months 2 Days 6 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Pocatello Ida
10. NAME OF FATHER Geo. W. Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bench Idaho
12. MAIDEN NAME OF MOTHER Bess Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois
14. Informant George W. Ellis Jr.
(Address) Soda Springs Ida
15. Filed 1-20-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jany (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1929, to Jan. 19, 1930
that I last saw him alive on Jan. 19, 1930
and that death occurred, on the date stated above, at 1:30 P. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis (non contagious ?)
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Marasmus
(duration) ..... yrs. 2 mos. ..... ds.
18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of 0
Was there an autopsy? No
What test confirmed diagnosis? Excess Spinal fluid
(Signed) Russell Tigert, M. D.
1/30, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 1-20 1930
20. Undertaker G. D. Whiteman — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69162

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isabel Harston

44

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Harston

6. DATE OF BIRTH (month, day and year) May 14, 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Richard S Horn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Price
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Geo Harston
(Address) Burley Ida

15. Filed 2-5-, 1930 F. H. Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Jan 30, 1930
that I last saw her alive on Jan 30, 1930
and that death occurred, on the date stated above, at 2:45 P. m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 1-1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Hugh E Wilson, M. D.
Feb. 1-, 1930 (Address) Beverly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	Feb. 4 1930

20. Undertaker D. C. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69164

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter Gunderson 92

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Malissa Gunderson

6. DATE OF BIRTH (month, day and year) Feb. 4 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Gunder Gunderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Sophia Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Edward Gunderson
(Address) Burley Idaho.

15. Filed 2/17, 1930 F. Hewitt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Jan 6, 1930
that I last saw h alive on 19
and that death occurred, on the date stated above, at 11.15P m.

The CAUSE OF DEATH* was as follows:

Mesentaric Thrombosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Joint Snow
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Joseph Henstead, M. D.
Jan 13, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burley Idaho — Date of Burial: Jan. 10 1930

20. Undertaker: D.E. Johnson Burley Ida — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69165

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Cook

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Cook

6. DATE OF BIRTH (month, day and year) Oct. 21, 1846

7. AGE Years 83 Months 2 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER James Port
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Garnett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Annie Severe
(Address) Burley Ida

15. Filed 2-15-, 1930 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Jan 9, 1930
that I last saw her alive on Jan 9, 1930
and that death occurred, on the date stated above, at 8:45 a m.
The CAUSE OF DEATH* was as follows:
Carditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
Jan 30, 1930 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Jan. 12 1930

20. Undertaker D. E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE... FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69166

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

57

2. FULL NAME Von Dale Doman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 13, 1918

7. AGE Years 11 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS
10. NAME OF FATHER Albert Orson Doman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Myrtle Beazer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ut

14. Informant A. O. Doman
(Address) Burley Ida

15. Filed 2-15-, 1930 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-24th 1930, to Jan-26-1930
that I last saw him alive on Jan 26 - 11 pm, 1930
and that death occurred, on the date stated above, at 11:05P m.
The CAUSE OF DEATH* was as follows:
Diabetis mellitus

— (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) -

- (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no -
What test confirmed diagnosis? - urine test
(Signed) G. H. Cooper, M. D.
1/31 -, 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Jan 29 1930

20. Undertaker D. E. Johnson
Address Burley

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69167

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

114

2. FULL NAME Byron J Wood

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 16 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Jesse E Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington
12. MAIDEN NAME OF MOTHER Beatrice Gorringe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida

14. Informant J E Wood
(Address) Burley Ida

15. Filed 2-18-, 1930 F R Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to 1-21, 1930
that I last saw h[illegible] alive on 1-21, 1930
and that death occurred, on the date stated above, at [illegible] m.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) F. R Carter, M. D.
1-25-, 1930 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Jan. 23 1930

20. Undertaker: R. C. Johnson — Address: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69168

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No. 161 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. **FULL NAME** Norman Theadore Baker

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 13 1927

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	2	11	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER James Baker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Betty Olson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant James Baker
(Address) Burley Ida.

15. Filed 2-10-30, 19 Registrar F. A. Cutler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1930, to Jan 26 1930,
that I last saw him alive on Jan 26 1930,
and that death occurred, on the date stated above, at 7:45 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Joseph Reynolds M. D.
Jan 20, 1930 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Jan. 19 1930

20. Undertaker W. C. Johnson Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69169

PLACE OF DEATH
County of Clark
City of Dubois

Registration District No. 120
Primary Registration District No. 2203
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. **FULL NAME** Hyrum Sultzbach

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Freighter - retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C W Miller
(Address) Dubois Idaho

15. Filed Jan 24, 1930 C E Jones M D
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:

General Debility

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C E Jones, M. D.
Jan 24, 1930 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dubois Idaho	Jan 25 1930
20. Undertaker None	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69170

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 96
Primary Registration District No. 2107
Local Registrar's No. 10
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME E. D. Faust

(a) Residence. No. ..... St. Lakeview, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? : yrs. : mos. : ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of Unascertained
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	93	?	?	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Jan 30, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 9, 1929, to January 29, 1930, that I last saw him alive on January 29, 1930, and that death occurred, on the date stated above, at 12.30 P.m.

The CAUSE OF DEATH* was as follows:
Exhaustion of senility
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Senile psychosis, simple type
(duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McElway, M. D.
January 29 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Jan 31 1930

20. Undertaker W. A. Shaw
Address Orofino

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69171

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

11 B

2. FULL NAME Anna H. Meade —

(a) Residence. No. ..... St. Harrison - Idaho -
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) United States.

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho -

15. Filed Jan 28, 1930 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926 to January 26, 1930
that I last saw her alive on January 26, 1930
and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:
Influenza

(duration) 0 yrs. 0 mos. 7 ds.
CONTRIBUTORY (Secondary) Senile psychosis
(duration) 7 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) Thurstonne McKelvey M. D.
January 26, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Idaho	Jan 30 1930
20. Undertaker	Address
H. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69172

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

1012

2. FULL NAME George W. Cummings

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carey Cummings

6. DATE OF BIRTH (month, day and year): June 5 1844

7. AGE — Years: 85 | Months: 7 | Days: 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Jacob Cumming
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: May Simpson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Carey L. Cumming
(Address): Orofino

15. Filed Jan 28, 1930. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-19-, 1930, to 1-29, 1930
that I last saw him alive on 1-28, 1930
and that death occurred, on the date stated above, at 5:15 a.m.
The CAUSE OF DEATH* was as follows:
Terminal Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Valvular heart affection
Arterio sclerosis (duration) many yrs. yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms -
(Signed) W. R. Fenton M. D.
1-29 1930 (Address) Orofino Idaho
Dr Copenhagen Consultation

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackston Ham — Date of Burial 19

20. Undertaker: H. A. Shaw — Address: Orofino

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69173

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 2107
(No.)
Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William F. Truesdell

(a) Residence. No. 81 St. Wallace, Idaho.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 6 - 1876

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	2	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Omaha, Nebraska.

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Emma East Dowling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed Jan 27, 1930. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 18-, 1928 to January 26, 1930
that I last saw him alive on January 26, 1930
and that death occurred, on the date stated above, at 1045 A. m.
The CAUSE OF DEATH* was as follows:
Chorea

(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with other brain or Nervous disease. (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs.
(Signed) John Crowe McKelway M. D.
January 26, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Wallace Ida	
20. Undertaker H. A. Shaw	Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69174

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 96
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 6

2. FULL NAME Al Russell

(a) Residence. No. ..... St. Grangeville, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) July 8, 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer - Mine laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Joseph Russell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Phoebe Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Jan 28, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 13, 1929, to January 21, 1930
that I last saw him alive on January 21, 1930
and that death occurred, on the date stated above, at 9.10 P.M.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with other somatic diseases (duration) 2 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
January 21, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Northern Idaho San. Cemetery	Jan. 22 1930
20. Undertaker	Address
F. A. Billberg, Hosp. attdt	Orofino, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69175

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2107
Local Registrar's No. 5
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Earl H. Poff

(a) Residence. No. ..... St. Lewiston, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
51	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER William T. Poff
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Mary E. Clay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Jan 21, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to January 21, 1930
that I last saw him alive on January 20, 1930
and that death occurred, on the date stated above, at 7 A.M. m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Cerebro-spinal syphilis, psychosis with (duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted, if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? C.S. & Spinal & blood Wassermann

(Signed) John Irvine McKelvey, M. D.
January 21, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Ida	
20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69176

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2107

Local Registrar's No. 4

(No.) 101 B.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Weston

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Allen Weston

6. DATE OF BIRTH (month, day and year) Jan 19th 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Corvallis, Ore.

PARENTS

10. NAME OF FATHER M. M. Marks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Allen Weston

(Address)

15. Filed Jan 20, 1930 V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 — 19 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-23, 1930, to 1-19-, 1930

that I last saw h 4 alive on 1-19-, 1930

and that death occurred, on the date stated above, at 6 P- m.

The CAUSE OF DEATH* was as follows: Pneumonia — Flu —

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

years — (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) M. R. Sterton, M. D.

1-20, 1930 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino — Date of Burial Jan 21 1930

20. Undertaker W. D. Pinson — Address

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69177

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2197
Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME Charlotte Chapin

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elmer D. Chapin

6. DATE OF BIRTH (month, day and year) Nov 12 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	2	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Cincinnatti Iowa

PARENTS

10. NAME OF FATHER Chas Reynolds
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Miss Cusk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Elmer D Chapin
(Address) Ahsahka Idaho

15. Filed Jan 16, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10, 1929, to Jan 14, 1930
that I last saw her alive on 12-29-29, 19....
and that death occurred, on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senile
(duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A.B. Pappenhagen, M. D.
1-15-30, 19.... (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Jan 16 19
20. Undertaker W. D. Pinney	Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69178

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

91B

2. FULL NAME Peter Johnson
(a) Residence. No. ..... St. Burke, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 1868

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Louis, Missouri

PARENTS

10. NAME OF FATHER Peter Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed Jan 13, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27, 1929, to January 9, 1930
that I last saw him alive on January 9, 1930
and that death occurred, on the date stated above, at 2.30 P. m.
The CAUSE OF DEATH* was as follows:
General arterio-sclerosis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arteriosclerosis (duration) 5 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
January 9 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Northern Idaho San. Cemetery
Date of Burial: Jan. 11 1930

20. Undertaker: F. A. Billberg, Hosp. Attdt.
Address: Orofino, Ida.

FEB 0 '30

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69179

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Orofino Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. One

179

2. FULL NAME Clarence Orr Kinnon

(a) Residence. No. Orofino Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 10 1919

7. AGE	Years	Months	Days	If LESS than 1 day,
	10	1	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Harrisberg Ida

PARENTS

10. NAME OF FATHER Joseph Allen McKinnon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Crystal Carmen
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Flora Ore

14. Informant Jos. A McKinnon
(Address) Grace Ida

15. Filed Jan 13, 1930 W. A. Pierce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1929, to Jan 12, 1930
that I last saw him alive on Jan. 11, 1930
and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:
Burns second + third degree of trunk one thigh + one arm from bon fire.
(duration) yrs. 3 mos. 13 ds.

CONTRIBUTORY (Secondary) Myocarditis + septicemia
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) R. J. Hopkins M. D.
1/12, 1930 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside	Jan 13 1930
20. Undertaker W. A. Pierce	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

PLACE OF DEATH

County of Clearwater

City of Orofino

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69180

Local Registrar's No. 1

1869

2. FULL NAME Charles Paulson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	?

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 40			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Clearwater Timbe Co

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W.A. Shaw Coroner
(Address) Orofino

15. Filed Jan 31, 1930. W.A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Accidental killed by log struck the head and broke his neck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W.A. Shaw Coroner, M. D.

Jan 31, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69181

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 96
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Eugene Emmett Donahue

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 7 1923

7. AGE: 6 Years | Months: 6 | Days: 30 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Pahsamaroi Valley
(State or country) Custer Co. Idaho

PARENTS

10. NAME OF FATHER Thos. J. Donahue
11. BIRTHPLACE OF FATHER (city or town) Mackay
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Flora B. Falls
13. BIRTHPLACE OF MOTHER (city or town) Pahsamaroi Valley
(State or County) Custer Co. Idaho

14. Informant (Address) Thomas J. Donahue Challis Ida.

15. Filed Jan 13, 1930 Edna McKinney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/30, 1929, to 1/6, 1930
that I last saw him alive on Jan 6th, 1930
and that death occurred, on the date stated above, at 8 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumococcic Meningitis

..... (duration) ..... yrs. 10 mos. wks. ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Spinal fluid
(Signed) C. L. Kirtley, M. D.
Jan 13, 1930 (Address) Challis, Ida.

19. Place of Burial, Cremation, or Removal: Mackay, Idaho | Date of Burial: Jan. 10 19..

20. Undertaker: Theo Garnier | Address: Mackay, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECD FEB 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69182

PLACE OF DEATH

County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M. Christensen 90
(a) Residence. No. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Lena Christensen

6. DATE OF BIRTH (month, day and year) Oct 21 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Crossing watchman O.S.L.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O.S.L.R.R.

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant J. F. Christensen
(Address) Shoshone Ida

15. Filed 1-21, 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Heart Failure
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Grant Hughes, M. D.
1-21, 1930 (Address) Coroner Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spanish Fork Utah	1-26 1930

20. Undertaker C. C. Hickok Address Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69184

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Smith

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ada Smith

6. DATE OF BIRTH (month, day and year) Apr 9 1893

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairview Idaho

PARENTS

10. NAME OF FATHER Charles Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Honor Rawlings
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Ada W. Smith
(Address) Fairview Idaho

15. Filed Feb 3, 1930 A. R. Auble Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 31, 1930
that I last saw him alive on Jan 31, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows: Post Operative Pneumonia

(duration) yrs. 1 mos. 2 ds.
CONTRIBUTORY (Secondary) Operation for Appendicitis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 29
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Farley M. D.
Jan 31, 1930 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairview Idaho — Date of Burial: Feb, 3 1930

20. Undertaker: M. W. Hendricks — Address: Preston

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69185

PLACE OF DEATH
County of Franklin
City of Dayton

Registration District No. 27
Primary Registration District No. 2119
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ....

57

2. FULL NAME Jacob Peterson

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline Peterson

6. DATE OF BIRTH (month, day and year) Jan 27 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	11	21	.... hrs. or .... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) Denmark
(State or country)

PARENTS

10. NAME OF FATHER Hanse Nelsen

11. BIRTHPLACE OF FATHER (city or town) Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Margurett Petersen

13. BIRTHPLACE OF MOTHER (city or town) Denmark
(State or Country)

14. Informant Carolina Peterson
(Address) Dayton Idaho

15. Filed Feb. 3, 1930 T. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 19, 1930
that I last saw him alive on Jan 18, 1930
and that death occurred, on the date stated above, at .... m.
The CAUSE OF DEATH* was as follows:
Diabetes & Pneumonia
.... (duration) .... yrs. .... mos. 10 ds.
CONTRIBUTORY
(Secondary)
.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Thos B Holder, M. D.
1/22, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dayton Idaho	Jan 22 1930

20. M. W. Hendricks Preston Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69186

PLACE OF DEATH
County of Franklin
City of Brendale

Registration District No. 27
Primary Registration District No. 2119
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ....

2. FULL NAME Richard Owen

(a) Residence. No. .... St. 1000 W
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Owen

6. DATE OF BIRTH (month, day and year) July 24 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	78	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Thomas Owen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Joyce Ritson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Elizabeth Owen
(Address) Glendale

15. Filed Feb. 4, 1930 A. R. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Jan 29, 1930, that I last saw h[illegible] alive on Jan 29, 1930, and that death occurred, on the date stated above, at 2 pm.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
.... (duration) — yrs. — mos. 6 ds.
CONTRIBUTORY (Secondary) General debility from old age — (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
Jan 30, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Preston Idaho — Date of Burial Feb. 2 1930

20. Undertaker M. W. Hendricks — Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69187

PLACE OF DEATH
County of Franklin
City of Winder

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Derris Nathalie Warrick

4

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 22 1917

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work SchoolGirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winder

PARENTS

10. NAME OF FATHER John G. Warrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ont/Mo.
12. MAIDEN NAME OF MOTHER Nathalie Carlson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Albert Carlson
(Address) Preston

15. Filed Feb. 1, 1930 A. R. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/26, 1930, to 1/30, 1930
that I last saw her alive on Jan 29, 1930
and that death occurred, on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Scarlet Fever

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? -
(Signed) Thos B Holder, M. D.
Jan 31, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Jan 30	1930

20. Undertaker Mrs. Handricks Preston Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69188

PLACE OF DEATH
County of Franklin
City of Fairview
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vernal A. Smith

(a) Residence. No. 91B St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 3 1903

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairview Idaho

PARENTS

10. NAME OF FATHER Richard James Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richmond Utah
12. MAIDEN NAME OF MOTHER Sarah Matilda Adams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kaysville Utah

14. Informant Sarah Mitilda Smith
(Address) Fairview Idaho

15. Filed Jan. 4, 1930. A. R. Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) — 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1, 1929, to 1-2, 1930
that I last saw him alive on 12-28, 1929
and that death occurred, on the date stated above, at 7:00 a m.
The CAUSE OF DEATH* was as follows:
Lateral sclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Butler, M. D.
Jan 3rd, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Idaho	Jan 4 30.

20. Undertaker M. W. Hendricks Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-13. RECEIVED FEB 10 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69189

Local Registrar's No.

1. PLACE OF DEATH

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

If death occurred in a hospital, institution or car give its NAME instead street and number.

2. FULL NAME Sophronia Ann Stephtnsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: whuta

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: July (Month) 22 (Day) 1878 (Year)

7. AGE: 51 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Richmond Utah

10. NAME OF Father: Issiac Bennett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Rose

13. BIRTHPLACE OF MOTHER (State or Country): Carson City Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. A. Stephensen

(Address) Preston Idaho

15. Filed Feb. 30 1930 A. R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1930 (Year) 144

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1930, to Jan 27 1930 that I last saw her alive on Jan 27 1930 and that death occurred on the date stated above, at 4:10 A

The CAUSE OF DEATH* was as follows:

Puerperal Hemorrhage

(Duration) — yrs. — mos. 2 hrs ds.

Contributory (Secondary) Childbirth

(Duration) — yrs. — mos. 1 ds.

(Signed) G. W. States M. D.

Jan 27 1930 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho Jan

DATE OF BURIAL: 30 30 19

20. UNDERTAKER: M. W. Hendricks

ADDRESS: Presyon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69190

PLACE OF DEATH
County of Franklin
City of Preston Ida

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

100a

2. FULL NAME James Alvin Jensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 26 1910

7. AGE: Years 18 Months 11 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Preston Idaho

PARENTS

10. NAME OF FATHER: James Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lago Idaho

12. MAIDEN NAME OF MOTHER: Amanda Sorensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mantua Utah

14. Informant: James Jensen
(Address): Preston Idaho

15. Filed Jan 13, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 9 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
that I last saw him alive on Jan 9, 1930
and that death occurred, on the date stated above, at 11:00 P m.
The CAUSE OF DEATH* was as follows:
Bronchi Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Post-paralysis of almost whole body from Acute Poliomyelitis 15 yrs ago
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler M. D.
Jan. 13, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho Jan — Date of Burial: 12 30

20. Undertaker: M. W. Hendicks — Address: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69192

PLACE OF DEATH
County of Elmore
City of Montour

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Jeremiah H. Albin

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): May 11 1851

7 AGE: Years 78 | Months 8 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10 NAME OF FATHER: Russell Albin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana
12 MAIDEN NAME OF MOTHER: Rachael Printy
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant: Ethel Albin
(Address): Montour Idaho

15 Filed 1-20 1930 J. K. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 16 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1930, to Jan 16 1930.
that I last saw him alive on Jan 16 1930.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) J. K. Reynolds
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. K. Reynolds M. D.
(Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Case Furniture Co
Date of Burial: 1-18 1930
20. Undertaker: Buried at Sweet Idaho
Address

DO NOT HAND COPY PRINT

FORM V. S. [illegible] RECEIVED FEB 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69193

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee Albert Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Jany (Month) 18 (Day) 1929 (Year)

7. AGE: ..... Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Emmett Idaho

10. NAME OF FATHER: Claud Albert Rogers

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Ida McNinch

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Claud A Rogers

(Address) Emmett

15. Filed 1-20 1930 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

160

16. DATE OF DEATH: Jan (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Baby died in bed at night
had not been sick
possibly a congenital heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.

1-20 1930 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McBratney

DATE OF BURIAL: 1-22 1930

20. UNDERTAKER: Bury at Boise Idaho

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69194

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James McRoberts 91B

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 19 - 1849

7. AGE Years: 80 Months: 2 Days: 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Peter McRoberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Margery Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: James McRoberts
(Address) Emmett Idaho

15. Filed 1/7, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Jan 6, 1930
that I last saw him alive on Jan 6, 1930
and that death occurred, on the date stated above, at 11 55 P m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis with uraemia from renal ~~hypo~~ insufficiency
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Prostate causing retention of urine & backpressure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
1/7, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 1/8 1930

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-26 M. 1-19.

RECEIVED FEB 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 69195
Registered No.

1. PLACE OF DEATH

County of Lemhi

City of Montour

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Keith Normand Hanley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Dec 24 - 1929
(Month) (Day) (Year)

7. AGE: Yrs. Mos. ds. 28

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montour Idaho

10. NAME OF FATHER: Relda St Clair Handley

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Ethel Hedy Church

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Relda St Clair Handley

(Address) Montour Idaho

15.

Filed 1-27 1930

J L Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from scalp- this child had a Malformation of head on fem side- from which it bled to death despite every effort

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.

1-27 1930 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Brownlee Idaho — DATE OF BURIAL: 1-25 1930

20. UNDERTAKER: Fatter — ADDRESS: Montour

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69196

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy May Rynearson
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12 - 1930

7. AGE Years: New Born | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS
10. NAME OF FATHER: Clarence R. Rynearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake Utah
12. MAIDEN NAME OF MOTHER: Naomi M. Clifford.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Woodville Idaho

14. Informant: Clarence R Rynearson
(Address) Emmett Idaho

15. Filed 1/13, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 At birth , 19
that I last saw her alive on Jan 12th 11 am 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Premature birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) possibly thyroid toxemia of mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
1/13, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho | Date of Burial: 1/13 1930

20. Undertaker: C D Bucknum | Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69197

PLACE OF DEATH
County of Ten
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Rural Edward Rynearson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12-1930

7. AGE Years: New Born | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS
10. NAME OF FATHER: Clarence R. Rynearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake Utah
12. MAIDEN NAME OF MOTHER: Naomi M. Clifford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Woodville Idaho

14. Informant: Clarence R Rynearson
(Address) Emmett Idaho

15. Filed 1/13, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth, to , 19
that I last saw h alive on at birth, 19
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Premature birth
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Possibly thyroid toxemia in mother (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
1/13, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho | Date of Burial: 1/13 1930

20. Undertaker: C D Bucknum | Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69198

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leo James Rynearson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12 - 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
New Born			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER Clarence R. Rynearson
11. BIRTHPLACE OF FATHER (city or town) Salt Lake
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Naomi M. Clifford
13. BIRTHPLACE OF MOTHER (city or town) Woodville
(State or Country) Idaho

14. Informant Clarence Rynearson
(Address) Emmett Idaho

15. Filed 1/13, 1930 J. K. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
at birth to , 19
that I last saw h alive on Jan 12, 1930
and that death occurred, on the date stated above, at 6 00 m.
The CAUSE OF DEATH* was as follows:
Premature birth
weak child
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Possibly Thyroid toxemia of Mother
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. K. Reynolds, M. D.
1/13, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	1/13 1930
20. Undertaker C. D. Bucknum	Address Emmett Idaho

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69214

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 321

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Broadhurst

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

14a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6- 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	9	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Louis Mo.

PARENTS

10. NAME OF FATHER Samuel Broadhurst
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Broadman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant R. L. Broadhurst
(Address) St. Anthony Idaho

15. Filed Jan. 31, 1930 Wm. Hanson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1930, to Jan 30, 1930
that I last saw him alive on Jan 30, 1930
and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Hypertension (Arterial)
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J A Ellison, M. D.
1/31, 1930 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker Cemetery	Feb. 1st 1930

20. Undertaker W. M. Hanson Address St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69215

PLACE OF DEATH

County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 320

10113

2. FULL NAME William Edward Hunter

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 30. 1858

7. AGE: Years 71 | Months 1 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired 10 years
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Grantsville Utah

PARENTS

10. NAME OF FATHER: Edward Hunter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Mary Ann Whiteside
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs Robert Hillman
(Address) Rexburg Route # 3.

15. Filed Jan 27, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 24, 1930
that I last saw him alive on Jan 24, 1930
and that death occurred, on the date stated above, at 9 30 P m.
The CAUSE OF DEATH* was as follows:
Pleurisy Pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Pleurisy

..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
....., 19.... (Address) St Anthony

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker City Cem. | Date of Burial: Jan 27th 1930

20. Undertaker: Vern J. Keller | Address: Rexburg

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69216

Registration District No.
Primary Registration District No.
Local Registrar's No. 319

(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Fremont
City of RFD #3.

2. **FULL NAME** William Andrew McMinn.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W.	Divorced.

5a. If married, widowed, ~~or divorced~~
HUSBAND of
~~(or) WIFE of~~ Louise Kritz

6. DATE OF BIRTH (month, day and year) Sept 3 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Farm work.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rich County Utah

PARENTS
10. NAME OF FATHER J. A. McMinn.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada. Halifax Nova Scotia
12. MAIDEN NAME OF MOTHER Georgana Pearce
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Jersey

14. Informant G. T. McMinn.
(Address) St Anthony R. #3.

15. Filed Jan 24, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19th, 1930, to Jan 21, 1930
that I last saw h[illegible] alive on Jan 21, 1930
and that death occurred, on the date stated above, at 7 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. Bryant M. D.
, 19 (Address) St Anthony

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker Cem.	Jan 24 1930
20. Undertaker	Address
Geo J. Keller	Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — FEB 12 1930

Registration District No. 99

Primary Registration District No. 2177

File No. 6921

Registered No. 318

County of Fremont

City of St. Anthony (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 9th (Day) 1849 (Year)

7. AGE: 80 Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Rawson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Chandler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jane Fowell
(Address) St. Anthony Idaho

15. Filed Jan. 19 1930 C. W. Ransom Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1929, to Jan 18 1930, that I last saw him alive on Jan. 16 1930 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis.

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Ellison M. D.

1/18 1930 (Address) St. Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery | DATE OF BURIAL: Jan 20 1930

20. UNDERTAKER: C. W. Ransom | ADDRESS: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69218

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 317

PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ephraim Wellis Jenkins

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 13-1850

7. AGE: Years 79 | Months 10 | Days 24 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): South Wales

PARENTS

10. NAME OF FATHER: Williams Wellis Jenkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): South Wales
12. MAIDEN NAME OF MOTHER: Elizabeth Rosser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): South Wales

14. Informant: W. E. Jenkins Jr
(Address) St. Anthony Idaho

15. Filed Jan 7, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 6. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd, 1930 to Jan 6, 1930
that I last saw him alive on Jan 6, 1930
and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH was as follows:*
Hemi-plegia

(duration) ____ yrs. ____ mos. 4 ds.
CONTRIBUTORY (Secondary) Chronic Brights
(duration) 3 yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Fundings
(Signed) P. M. Kelly M. D.
Jan 6, 1930 (Address) St. Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker Cemetery — Date of Burial: Jan 9 1930
20. Undertaker: W. M. Hansen — Address: St. Anthony Idaho

FORM V. S. No. 5-8 RECEIVED FEB 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 6922.4
Registered No. 121

1. PLACE OF DEATH
County of Goodding
City of 11
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Missouri Brashears

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) ~~Widowed~~

6. DATE OF BIRTH: April (Month) 16 (Day) 1842 (Year)

7. AGE: 87 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Charles La Forge

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. B. Slater
(Address) Goodding Idaho

15. Filed 1-31 1930
J. H. Cornwall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1929, to Jan 22 1930, that I last saw her alive on Jan 21 1930, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Fracture of femur
Cystitis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Fell in house

(Duration) yrs. mos. ds.

(Signed) J. H. Cornwall M. D.
19 (Address) Goodding, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elmwood Cemetery Goodding
DATE OF BURIAL: Jan 24 1930

20. UNDERTAKER: A. E. Thompson
ADDRESS: Goodding Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

RECEIVED MAY 2 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69224

Dr. J.H. Cornwell
Gooding, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Missouri Bishop who died at Gooding, Idaho on Jan. 22, 1930
Cause of death given as "Fracture of femur" "Asthenia"

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Patient very feeble from age fell in house & broke femur, from which she died some months later.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69225

Registered No. 120

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 24

County of

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Franklin Ikard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1891 (Year)

7. AGE: 38 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla.

10. NAME OF FATHER: Milton F Ikard

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Virginia Blair

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Cranwell
(Address) Gooding Idaho

15. Filed 1-30 1930 J H Cranwell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1929 to Jan 6 1930
that I last saw h.. alive on Jan 6 1930
and that death occurred on the date stated above, at 10:20 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E Snyder M. D.
1-6 1930 (Address) Gooding

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 6 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Gooding Idaho.

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: Jan 8 1930

20. UNDERTAKER: A E Thompson — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 69226
Registered No. 119

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jerome Eugene Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 13 (Day) 1908 (Year)

7. AGE: 22 Yrs. Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shoshone Idaho

10. NAME OF FATHER: LeRoy Jones

11. BIRTHPLACE OF FATHER (State or Country): Gage Co Nebr

12. MAIDEN NAME OF MOTHER: Sarah Johnson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) LeRoy Jones
(Address) Gooding

15.
Filed 1-31 1930
J H Cranwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1930, to Jan 28 1930, that I last saw him alive on Dec 15 1930, and that death occurred on the date stated above, at 10:20 P.M.
The CAUSE OF DEATH* was as follows:
Consumption
(Pulmonary tuberculosis)
(Duration) Yrs. 1 mos. 8 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J H Cranwell M. D.
19 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding - Old Cemetery
DATE OF BURIAL: 1-31- 1930

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. RECEIVED FEB 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 69227

Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Franklin Trullinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 19 (Day) 1853 (Year)

7. AGE: 76 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired blacksmith

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Clackames Co. Ore.

10. NAME OF FATHER: Nathan H. Trullinger

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Frances Grisham

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Milton Trullinger

(Address) Gooding Ida

15. Filed 1-29- 1930

J. H. Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1930 to Jan 27 1930 that I last saw h. in alive on Jan 26 1930, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Brights Disease (Chronic)

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) (Dropsy-)

(Duration) yrs. 4 mos. ds.

(Signed) J H Cromwell M. D.

1/27 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Elmwood - Gooding

DATE OF BURIAL: 1-28- 1930

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M-1-22

RECEIVED FEB 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 69228
Registered No. 117

1. PLACE OF DEATH
County of Gooding
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chauncey Albertus Burke
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1870 (Year)

7. AGE: 59 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sandusky Ohio

10. NAME OF FATHER: Issah P. Burke

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary S Steels

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alice Burke
(Address) Gooding Ida

15. Filed 1/31 1930 J H Cranwell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

118 B

16. DATE OF DEATH: January (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1930, to Jan 12 1930
that I last saw him alive on Jan 12 1930,
and that death occurred on the date stated above, at 1:28 P.M.
The CAUSE OF DEATH* was as follows:
Acute chorea

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J H Cranwell M. D.
19 (Address) Gooding

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding Ida — DATE OF BURIAL: 1/15 1930

20. UNDERTAKER: Thompsons — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69230

PLACE OF DEATH

County of Idaho
City of Kooskia
Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 291

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Merton Denison

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lizzie Denison

6. DATE OF BIRTH (month, day and year) July 8 - 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sioux City - Iowa

PARENTS

10. NAME OF FATHER Augustus Denison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not obtainable
12. MAIDEN NAME OF MOTHER Mary Ann Hartley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not obtainable

14. Informant G. W. Denison
(Address) Kooskia Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9 40 p.m.

The CAUSE OF DEATH* was as follows:
Pernicious Anaemia
(Saw medical attendant for last 3 months)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Tarbet M. D.
Jan 4, 1930 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Tahor Cemetery	January 5 1930
20. Undertaker	Address
—	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69231

Registration District No. 106

Primary Registration District No. 2184

Local Registrar's No. 292

1000

PLACE OF DEATH

County of Idaho

City of Kutes

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Looking Glass

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Indian	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Looking Glass

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not obtainable

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not obtainable

14. Informant Henry Elk

(Address) Kutes Idaho

15. Filed Jun 9 1930 J M Verbeek Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 8, 1930

that I last saw h[illegible] alive on Jan 8, 1930

and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Verbeek M. D.

Jun 9, 1930 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah (Family Cemetery)	Jan 13 1930
20. Undertaker Leo Freeman	Address Kooskia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69232

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 293

2. FULL NAME Frederick Emery Flynn, 10a
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lydia Flynn.

6. DATE OF BIRTH (month, day and year) July 23 - 1863

7. AGE Years 66 Months 5 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Van Kleek Hill Ontario

PARENTS
10. NAME OF FATHER Benjamin D Flynn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario Canada
12. MAIDEN NAME OF MOTHER Margaret Thistlewaite
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario Canada

14. Informant Lydia Flynn
(Address) Kooskia Idaho

15. Filed Jan 14, 1930 J M Verbeekmoss Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jan 12, 1930
that I last saw him alive on Jan 8, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
Exhaustion
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H W Wentworth M. D.
Jan 12, 1930 (Address) Stites Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clearwater
Date of Burial Jan 14 1930

20. Undertaker Geo Tierney
Address Kooskia

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 105

Primary Registration District No. 2183

File No. 60223

County of Idaho

City of Ferdinand (No. ..... St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anton William Frei

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: November (Month) 4 (Day) 1929 (Year)

7. AGE: Yrs. 2 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ferdinand, Idaho

10. NAME OF FATHER William Frei

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Elizabeth Staab

13. BIRTHPLACE OF MOTHER (State or Country) Rush Lake, Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Frei
(Address) Ferdinand Idaho.

15. Filed 1/23 1930 A. F. Orr Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1930, to Jan. 21 1930, that I last saw him alive on Jan. 21 1930, and that death occurred on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Meningetis,

(Duration) 1 Yrs. ..... mos. 3 ds.

Contributory (Secondary) Bronchial Pneumonia,

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Wesley F. Orr M. D.

1/23 1930 (Address) Cottonwood, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ferdinand, Idaho	Jan. 24 1930

20. ~~UNDERTAKER~~ ADDRESS
Father Heaman, Ferdinand, Idaho,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69240

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 30
Primary Registration District No. 1650
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

K68C

2. FULL NAME Carl A. Mayo
(a) Residence. No. Seattle, Wn. St. Seattle Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Edna A. Mayo

6. DATE OF BIRTH (month, day and year)

7. AGE Years 58 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Seattle Wn
(c) Name of employer Gen Laundry Machine Corp

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Coroners Office
(Address) Coeur d Alene Ida.

15. Filed 1-29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 2:15 P m.
The CAUSE OF DEATH* was as follows:
accidently Drowning
(auto accident Car Run of Bridge over Coeur d Alene River)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) R B Mooney Coroner ~~M. D.~~
Jan 12, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seattle Wn. Date of Burial Jan 14 1930

20. Undertaker R B Mooney Address Coeur d Alene

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69241

PLACE OF DEATH
County of Kootenai
City of Post Falls (Hauser Lake)

Registration District No. 30
Primary Registration District No. 1050
(No. Hauser Lake, Wash. Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

74 A

2. **FULL NAME** Ole S. Lunsol

(a) Residence. No. ..... St. Post Falls. Idaho R. 1.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not obt.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Severt Lunsol
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not obt.

14. Informant Nelson Ware
(Address) Post Falls - Idaho, R. 1.

15. Filed 1 27, 1930 N. J. Stringfield Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 19. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 19., 1930, to Jany 19., 1930
that I last saw h— alive on Jany 19., 1930
and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage - 2
Strokes of apoplexy with
Hemiplegia -
(duration) yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) General Arterio -
Sclerosis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Ware, M. D.
1/20., 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	Jan. 22 1930
20. Undertaker	**Address**
Smith Funeral Home	Spokane Wash

Parts not obtainable 6-12 + 13 - by Katherine Koetzer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69242

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Oluse Moline

(a) Residence. No. Post Falls, Ida., St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) aug 14. 1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	3	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER P. O. Moline
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Christina Pierson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Mrs Sarah Haralson
(Address) Post Falls, Ida.

15. Filed 1-29, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1930, to Jan 13th, 1930
that I last saw him alive on Jan 13th, 1930
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchial Asthma
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms: objective & subjective
(Signed) P. L. McCauley M. D.
Jan 16, 1930 (Address) Post Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fort Cemetery	1-16 1930
20. Undertaker	Address
P B Mooney	Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69243

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1030

Local Registrar's No. 44

(No. 1004 A St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100 W

2. FULL NAME Elizabeth Casey

(a) Residence. No. 1104 A St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 15-1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	8	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Powers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Joseph Buckle
(Address) Hayden Lake

15. Filed 1-29, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1930, to Jan 14, 1930
that I last saw her alive on Jan. 14, 1930
and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Physical exam.
What test confirmed diagnosis?

(Signed) J O Dwyer, M. D.
Jan 16, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cemetery	Jan 17 1930
20. Undertaker	Address
P. G. Mooney	Pd'A Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69244

PLACE OF DEATH

County of Kootenai
City of Rathdrum
Registration District No. 30
Primary Registration District No. 1000
Local Registrar's No. 5
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cyprus L Sage
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie B. Sage

6. DATE OF BIRTH (month, day and year) July 22 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	5	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter - Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER David C. Sage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Helen M. Farrd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Hugh R. Sage
(Address) Lester, Wash.

15. Filed 1-24, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to January 7, 1930
that I last saw h... alive on January 6. 1930
and that death occurred, on the date stated above, at 6.00 A m.

The CAUSE OF DEATH* was as follows:
Valvular (mitral) Heart Disease
about 3 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
& dropsy about 1½ (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Ware, M. D.
1/8, 1930 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery - Rathdrum	1/9 1930
20. Undertaker	Address
Cassidy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69246

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1650
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

48a

2. FULL NAME Berenice Nellie Jensen
(a) Residence. No. Hauser Lake Route St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 17 1922

7. AGE Years 7 Months 4 Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS
10. NAME OF FATHER Harry Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chicago
12. MAIDEN NAME OF MOTHER Nellie Lindrey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Do not know

14. Informant Mrs. Nellie Jensen
(Address) Post Falls Idaho

15. Filed Jan 29, 1930 H. J. Stierges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 20. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Jany 20, 1930
that I last saw her alive on Jany 18, 1930
and that death occurred, on the date stated above, at 10.50 a m.
The CAUSE OF DEATH* was as follows:
Acute Endocarditis with Stenosis of mitral valve
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Scarlet fever
(duration) yrs. 2 mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wenz, M. D.
1/20, 1930 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Post Falls Idaho
Date of Burial 1/22 1930

20. Undertaker Cassidy Funeral Home
Address Rathdrum

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69247

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 8

(No.) 1013

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sven Axel Gullberg

(a) Residence. No. Coeur d'Alene R. # 1. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1903 - 11 - 16

7. AGE	Years	Months	Days	If LESS than 1 day,
	26	2	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Axel Gullberg

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Tilda Gustafson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Alfred Gustafson

(Address) Coeur d'Alene, Ida.

15. Filed 1-29, 1930. H. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Jan 24, 1930

that I last saw h-im alive on Jan 24, 1930

and that death occurred, on the date stated above, at 12:40 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examn

(Signed) Harold J. Sturgess, M. D.

Jan 24, 1930 (Address) C. d'A. Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem	1-27 1930
20. Undertaker	Address
Cassidy Funeral Home	C. d'A.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69248

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 9

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John William McCrea

(a) Residence. No. 602 Government Way St.
(Usual place of abode)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clara McCrea

6. DATE OF BIRTH (month, day and year) Oct 16 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	3	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Grain Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Cd'A Grain & Milling Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER J. Matthew McCrea
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs Clara E. McCrea
(Address) Coeur d'Alene Idaho

15. Filed 1-29, 1930 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to January 24, 1930
that I last saw him alive on January 24, 1930
and that death occurred, on the date stated above, at 3:30 A m.
The CAUSE OF DEATH* was as follows:

Cardiac Decompensation
(duration) yrs. 8 mos. 22 ds.
CONTRIBUTORY (Secondary) Myocardial degeneration
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson, M. D.
January 25, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place [redacted] Cremation, [redacted]	Date of Burial
Spokane, Wash.	Jan 29 1930
20. Undertaker	Address
T. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69249

PLACE OF DEATH
County of Kootenai
City of
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 10
(No.) 46 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William J. Cornwell

(a) Residence. No. x Hayden Lake St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl Cornwell

6. DATE OF BIRTH (month, day and year) Nov 2 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Johnson Cornwall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Eliza Humphry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs Pearl Cornwell
(Address) Hayden Lake Ida

15. Filed 1-29, 1930 A. J. Sturgeo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Janu 11, 1930, to Janu 19, 1930
that I last saw him alive on Janu 14, 1930
and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
about 3 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Slight Kick of a horse
in the face (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wang, M. D.
1/20, 1930 (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Jan 22 1930
20. Undertaker T. B. Mooney	Address Coeur d Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69250

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

44

2. FULL NAME Margeret Marie Carey
(a) Residence. No. 1003 North 4th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J H Carey

6. DATE OF BIRTH (month, day and year) May 2 1897

7. AGE Years 32 Months 8 Days 16 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kalispell Montana

PARENTS
10. NAME OF FATHER Amel Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J H Carey
(Address) Coeur d'Alene Idaho

15. Filed 1-29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October, 1929, to Jan 18, 1930
that I last saw her alive on Jan 15, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Nov. 15
Was there an autopsy? No
What test confirmed diagnosis? Exam. of tissue at operation
(Signed) J C Dawson M. D.
Jan 30, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial Jan 21 1930

20. Undertaker R. B. Mooney
Address Coeur d'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69251

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 12
(No. 1613)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emanuel Powell.

(a) Residence. No. 1317 - 7th. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 - 1 - 15

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene Ida.
(State or country)

PARENTS

10. NAME OF FATHER Luther Powell
11. BIRTHPLACE OF FATHER (city or town) Ind.
(State or Country)
12. MAIDEN NAME OF MOTHER Bessie McGinnis
13. BIRTHPLACE OF MOTHER (city or town) Ill.
(State or Country)

14. Informant Luther M. Powell
(Address)

15. Filed 1-29, 1930 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to Jan. 15, 1930
that I last saw h~~im~~ alive on Jan. 15 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Birth asphyxiation
1¼ hours.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold T. Anderson, M. D.
Jan. 17, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C'D'Alene	1-17 1930
20. Undertaker	Address
Cassedy Funeral Home	C'D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69252

PLACE OF DEATH
County of Kootenai
City of Pathdrum

Registration District No. 30
Primary Registration District No. 1650

Local Registrar's No. 13

(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Barry

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 3 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pathdrum
(State or country) Idaho

PARENTS

10. NAME OF FATHER William R Barry
11. BIRTHPLACE OF FATHER (city or town) Afton
(State or Country) Okla
12. MAIDEN NAME OF MOTHER Columbia Stephenson
13. BIRTHPLACE OF MOTHER (city or town) Monnett
(State or Country) Missouri

14. Informant
(Address) Wm R Barry Pathdrum

15. Filed 2-7, 1930 N. J. Stunges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to Jan, 1930
that I last saw her alive on Jan 2, 1930
and that death occurred, on the date stated above, at 5 9. m.
The CAUSE OF DEATH* was as follows:
Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? organs
(Signed) Harold J. Stunges M. D.
Jan 14, 1930 (Address) Pathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery - Ethol	1-7 1930

20. Undertaker Carey Funeral Home — Address Pathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69253

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205a

2. FULL NAME Jos. W. Malkson
(a) Residence. (Usual place of abode) No. Fruitland addition St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Julia Malkson
6. DATE OF BIRTH (month, day and year) 1870 May 14
7. AGE Years 59 Months 7 Days 9 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Mill Worker
(c) Name of employer Blackwell Lbr Co.
9. BIRTHPLACE (city or town) (State or country) New Brunswick Canada

PARENTS
10. NAME OF FATHER Rufus Malkson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Brunswick Can.
12. MAIDEN NAME OF MOTHER Phebe Schools
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Carrie E. Williams
(Address)

15. Filed 2-7, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 25 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Only Examiner, Body, immediately, 19..
that I last saw him after accident, 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Killed by accident. Crushed under truck load of lumber falling on him
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. O. Dunn, M.D.
Jan. 27, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 1-28 1930
20. Undertaker Cassedy Funeral Home — Address C D Alene.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6925

PLACE OF DEATH
County of Kootenai
City of
Registration District No.
Primary Registration District No.
(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 15

2. FULL NAME Etta J. King
(a) Residence. No. Sunnyside St. 1010
(Usual place of abode)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C A King

6. DATE OF BIRTH (month, day and year) Feb 5, 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	11	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St Paul
(State or country) Minn.

PARENTS

10. NAME OF FATHER H. Bromley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Anna Gillette
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant C A King
(Address) Cd'A Ida R F D

15. Filed 2-1, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-16-, 1930, to 1-26, 1930
that I last saw her alive on 1-26, 1930
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Cholecystotomy
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1-20-26
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) E H. Teed M. D.
1-27-, 1930 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Jan 29 1930
20. Undertaker	Address
R. B. Mooney	Cd'A Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69255

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 16

(No.) 126
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Wm Hyde

(a) Residence. No. St. Chilco, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Laura Anna Hyde

6. DATE OF BIRTH (month, day and year): 1868-4-9

7. AGE — Years: 61 | Months: 9 | Days: 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Dont-Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.
12. MAIDEN NAME OF MOTHER: Dont-Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Laura A Hyde
(Address) Chilco

15. Filed 2/11, 1930. W. J. Sturges, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1929 to Jan 9, 1930
that I last saw him alive on Jan 9, 1930
and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Ch. Prostatitis -
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Jan 3rd 1930
Was there an autopsy? No
What test confirmed diagnosis? Exam. Lab. test
(Signed) Harold J. Sturges, M. D.
Jan 10, 1930 (Address) Ida. Dalton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rathdrum Ida — Date of Burial: 1-12 1930
20. Undertaker: Cassedy Funeral Home — Address: Dalton

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Dwyer

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69256

PLACE OF DEATH
County of Kootenai
City of
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 17
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph A. Strohorn

(a) Residence. No. Hayden Lake St. 43
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Strohorn

6. DATE OF BIRTH (month, day and year) July 3 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	6	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Joseph Strohorn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.
12. MAIDEN NAME OF MOTHER Orentt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Clyde Strohorn
(Address) Hayden Lake, Ida.

15. Filed 2-7, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1930, to Jan. 24, 1930
that I last saw h[illegible] alive on Jan. 22, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

Cancer of face.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? -

(Signed) J. C. Dwyer M. D.
Jan. 27, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Jan 27 1930
20. Undertaker	Address
W B Mooney	Coeur d Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69257

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 18
(No. Coeur D' Alene Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Erick Holm

(a) Residence. No. Cougar Gulch St.
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Christinaa Holm

6. DATE OF BIRTH (month, day and year) Sept. 6, 1877

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	3	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER Erick Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Mrs. Christina Holm
(Address) Coeur D' Alene, Idaho

15. Filed 2/11, 1930 A. J. Sturges. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 29, 1929, to January 4, 1930
that I last saw h[illegible] alive on January 4, 1930
and that death occurred, on the date stated above, at 10:40 P. m.
The CAUSE OF DEATH* was as follows:
Cardiac Failure
(duration) yrs. one mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Pneumokoniosis
(duration) 14 yrs. mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold T. Anderson, M. D.
Jan. 6, 1930 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	1/7 1930
20. Undertaker	Address
R. B. Mooney	Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69258

Local Registrar's No. 19

Registration District No. 30
Primary Registration District No. 1055

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
(No. Coeur d'Alene Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reuben C Letterstein

(a) Residence. No. 2 docks 7 Hotel. St. Tacoma, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. — mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
About	45			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumber Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) Chicago Milwaukee
(c) Name of employer R.R.

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant N. E. Hale
(Address) Tacoma Wn.

15. Filed 2/11, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Jan. 6, 1930
that I last saw him alive on Jan. 6, 1930
and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis
Uremic Coma.
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. L. Allwood, M. D.
Jan. 7, 1930 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Marinette Wis	Jan 7th 1930
20. Undertaker A B Mooney	Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECE... FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69259

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 20

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Russell Hallwork. 41

(a) Residence. No. 926 River St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929. 5 -21

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	7	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene, Ida
(State or country)

PARENTS

10. NAME OF FATHER Conrad Hallwork
11. BIRTHPLACE OF FATHER (city or town) Norway
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret Eriksen
13. BIRTHPLACE OF MOTHER (city or town) Sweden
(State or Country)

14. Informant Conrad Hallwork
(Address) Coeur d'Alene Ida.

15. Filed 2/11/ 1930 A. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1929, to January 7, 1930
that I last saw him alive on January 7, 1930
and that death occurred, on the date stated above, at 11:05 A. m.

The CAUSE OF DEATH* was as follows:
Septicemia, following simusitis and acute suppurative otitis media left
(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Herbert T. Anderson, M. D.
January 10, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	1-10 1930
20. Undertaker Cassedy Funeral Home	Address CDAlene

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69261

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 22

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48(2

2. **FULL NAME** Lillian Belle Madson.

(a) Residence. No. 1515 - 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Madson

6. DATE OF BIRTH (month, day and year) 1868 - 11 - 1

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine.

PARENTS

10. NAME OF FATHER Ephran Benjamin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Mina Sawyer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis.

14. Informant Nels. Madson
(Address) 1515 6th St.

15. Filed 2/11/, 1930. H. J. Burges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1927, to Jan, 1930, that I last saw her alive on June 8, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Exam
(Signed) Harold J. Burges, M. D.
June 11, 1930 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. CDAlene	1-11 1930

20. Undertaker Cassedy Funeral Home Address CDAlene

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69262

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
(No. Coeur d'Alene Hosp.)
Local Registrar's No. 23
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Bernhard Christofferson

(a) Residence. No. 722 Sunnyside St.
(Usual place of abode)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Christofferson

6. DATE OF BIRTH (month, day and year) Sept 26 - 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	3	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer) Winton Lumber Co
(c) Name of employer Coeur d'Alene & Pa.

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Christopher Davidson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Ellen Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs Martha Christofferson
(Address)

15. Filed 2/11, 1930 W. J. Sturges. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan. 12, 1930
that I last saw h— alive on Jan 12, 1930
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:
Hemiplegia, right
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 1½ yrs. mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold I. Anderson M. D.
Jan. 15, 1930 (Address) Coeur d' Alene, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Jan 15 1930

20. Undertaker T. B. Mooney Address Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 7 1930

PLACE OF DEATH

County of Latah

City of Deary

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69263

Local Registrar's No. .....

164

2. FULL NAME Gust J. Halen

(a) Residence. No. ..... St. .....
(Usual place of abode)

Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 6 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	0	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Johanson Endurson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mary Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs J. Halen

(Address) Deary Ida

15. Filed Jan 31, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 31st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1930, to Jan 31st, 1930,
that I last saw him alive on Jan 31st, 1930,
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Chas. A. Meyer, M. D.

Feb. 3, 1930 (Address) Troy Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Dry creek cem	
20. Undertaker	**Address**
John J. Pickird	Troy Ida.

RECEIVED FEB 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69264

PLACE OF DEATH
County of Latah
City of Troy

Registration District No.
Primary Registration District No. 1
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Emma Ella Kiteh 92

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Guy Kiteh

6. DATE OF BIRTH (month, day and year) June 24-1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur Oregan

PARENTS

10. NAME OF FATHER George Wright-
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ore
12. MAIDEN NAME OF MOTHER Adelia Demeau
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant George Wright-
(Address) Troy Ida.

15. Filed Jan 31, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 24, 1930
that I last saw her alive on Jan 24, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Coronary embolism.
Procidentia, chronic ovarian disease.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 11, 1930
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Geo F. Meyer, M. D.
Jan 28, 1930 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry creek cem	Jan 28 1930
20. Undertaker John J. Pickard	Address Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 18 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69264

Dr. C.A. Meyer
Troy

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Anna Ella Kilch who died at Troy, Idaho on Jan. 24, 1930
Cause of death given as "Coronary Embolism. Chronic Myocarditis."

Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Precidentia, Chronic ovarian disease.

C. A. Meyer MD

RECEIVED FEB 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69265

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Leonard Leona Nobles 161a

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 ~~Single, Married, Widowed, or Divorced~~ (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 24 1930

7 AGE: Years 0 | Months 0 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Troy Idaho

PARENTS

10 NAME OF FATHER Leonard Nobles
11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn
12 MAIDEN NAME OF MOTHER Cora Wardell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Potter Co Montana

14 Informant Leonard Nobles
(Address) Troy Idaho

15 Filed Jan 31, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 26. 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1930 to Jan 26 1930
that I last saw her alive on Jan 26 1930
and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:
Sexual weakness due to premature birth.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza of mother
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M. D.
Jan 26, 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow Ida — Date of Burial: Jan 27 1930
20. Undertaker: John J. Pickard — Address: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69266

PLACE OF DEATH

County of Latah
City of Palouse
Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No. Pallatch Hospital Association Hospital
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME John Carl Riel

(a) Residence. No. 102 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 30 / 1859

7. AGE — Years: 70 | Months: 0 | Days: 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas.

PARENTS

10. NAME OF FATHER: J. C. Riel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Mrs Edna Leistner
(Address): Palouse Wash.

15. Filed Jan 1st, 1930 Dr. J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30. 1929, to Jan 2nd, 1930
that I last saw him alive on Jan 2nd, 1930
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:

Acute Empyema Pleurisy.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Empyema.
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec 31st
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. W. Thompson M. D.
Jan 2nd, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Garfield — Date of Burial: Jan 5 1930
20. Undertaker: E. H. Truax — Address: Palouse Wash

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69267

PLACE OF DEATH

County of Latah
City of Potlatch
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Potlatch Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edwin M. Nicolai 44

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 13 - 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Molding Grader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Potlatch Lumber Co

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Louis Nicolai
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Bertha Kuneth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant E. G. Nicolai
(Address) Garfield Washington

15. Filed Jan 21, 1930 J. J. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1929, to Jan 1, 1930
that I last saw him alive on Jan 1
and that death occurred, on the date stated above, at 10 30 P m.
The CAUSE OF DEATH* was as follows:

Brain Abscess.

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Frontal Sinusitis
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. C. Ebron, M. D.
Jan 1, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Silver Creek Cem	Jan 4 1930

20. Undertaker E. M. Irwin Address Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

REC'D FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69269

PLACE OF DEATH

County of Latah
City of Potlatch
Registration District No. 65
Primary Registration District No. 2145
(No. Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Stephen Irwin West. 92

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 20 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	9	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10. NAME OF FATHER: C. B. West.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Margret Isaminger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Mrs L. I. West
(Address): Potlatch Wash.

15. Filed Feb. 5 1930 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1930, to Feb 3 1930, that I last saw h[illegible] alive on Feb. 3 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:
Embolism following operation of prostatectomy
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Feb 2
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. C. Gibson M. D.
Feb 5 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grange burn	Feb 6 1930
20. Undertaker	Address
E. H. Irwin	Potlatch Wash.

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69270

PLACE OF DEATH

County of Latah Registration District No. 101 Local Registrar's No. 1

City of Moscow Primary Registration District No. 2141

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Shaw

(a) Residence. ~~No.~~ Cornwall ~~St.~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Jennie Shaw (or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar. 12, 1853

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
76	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Guthrie County Iowa

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Cliff Hobart

(Address) Tekoa, Wash.

15 Filed Jan 16, 1930 W. J. Hawthorne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January (Month) 16, 1930 (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 1929 to Jan 16, 1930 that I last saw him alive on Jan 16, 1930 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Myo and Endo Carditis

Hypostatic Pneumonia

(duration) one yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Magee, M. D.

1/18/30, 19 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow	1/18/30 19

20. Undertaker H. R. Short Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69271

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Latah — Registration District No. 61
City of Moscow — Primary Registration District No. 1011
(No.) Local Registrar's No. 2
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Louisa Mc Connell

(a) Residence. No. 620 East 'B' St.
(Usual place of abode) (If nonresident give city, town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. J. Mc Connell

6 DATE OF BIRTH (month, day and year) July 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chic

PARENTS
10 NAME OF FATHER Benj. Brown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known ###.
12 MAIDEN NAME OF MOTHER Julia Blaisdel
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Carrie Bush
(Address) Moscow, Idaho

15 Filed Jan 27, 1930 W J Hoaruthers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 27, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930 to Jan 27, 1930
that I last saw her alive on Jan 27, 1930
and that death occurred, on the date stated above, at 7:35 A m.

The CAUSE OF DEATH* was as follows:

Acute Myo carditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C O Armstrong M. D.
1/28 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow, Ida. — Date of Burial: 1/29/30
20. Undertaker: H. R. Short — Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69272

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011

Local Registrar's No. 3

(No. 124)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Daniel Featherston

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 24 - 1921

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	2	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Helmer Idaho

PARENTS

10. NAME OF FATHER William Featherston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary Bywaters

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tolayse Wash

14. Informant William Featherston
(Address) Bovill Ida

15. Filed Jan 27, 1930 W. T. Hoaruthers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1930 to Jan 27, 1930
that I last saw him alive on Jan 23, 1930
and that death occurred, on the date stated above, at 12 55 a m.
The CAUSE OF DEATH* was as follows:

Acute nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Chas. L. Freiman, M. D.
1-28-1930, 19 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash.	Jan 29 1930

20. Undertaker J. M. Jones Address Palouse Wash

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69273

PLACE OF DEATH

County of Latah — Registration District No. 101
City of Moscow — Primary Registration District No. 1011
(No.) Local Registrar's No. 4
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

89

2. **FULL NAME** Cesar Bennett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of Grace Kline Bennett
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Mar. 13, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): LeRoy Ill

PARENTS
10 NAME OF FATHER: James Bennett
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio
12 MAIDEN NAME OF MOTHER: Sarah Rinehart
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: R.K. Bennett
(Address): Moscow, Ida.

15 Filed Jan 31, 1930 W.J. Hawthorne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: January 31, 1930 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 31, 1930
that I last saw h~~im~~ alive on Jan 31, 1930
and that death occurred, on the date stated above, at 2:05 P.m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only.
(Signed) O.O. Armstrong, M. D.
2/1, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
LeRoy, Ill.	
20. Undertaker: H. R. Short	Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69280

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 95
Primary Registration District No. 1009
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

11B

2. FULL NAME Mrs. A. W. Bailey

(a) Residence. No. Winchester Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Bailey

6. DATE OF BIRTH (month, day and year) Sept 13 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mont.

PARENTS

10. NAME OF FATHER Alex Jette
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Matilda —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Albert Bailey
(Address) Winchester Idaho

15. Filed Jan 1, 1930 Susan E. Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 27, 1930 that I last saw he alive on Jan 27, 1930 and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab + Physical exam.
(Signed) Ralph M. Allen, M. D.
Jan 27, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Missoula Mont	1930
20. Undertaker	Address
Pastor Mortuary	Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69281

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No.
Primary Registration District No.
(No. Nichols Farm North Shoshone
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ~~20~~ 1 one

2. FULL NAME Ida Anneta Nichols 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Kasper Nichols

6. DATE OF BIRTH (month, day and year): Jan 21

7. AGE: Years 52 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS
10. NAME OF FATHER: Joe Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Mary Gail
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Orin R Beck
(Address): Gridley Calif

15. Filed Jan 6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I did not attended deceased ~~from~~ 19 to 19
that I last saw h I found woman dead at alive on 8:30 P.M. Jan 3, 1930
and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:
Heart attack probably Chronic Myocarditis
(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Obesity
(duration) ✓ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) F. E. Barrett, M. D.
Jan 4, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gridley Calif
Date of Burial: 1-9 1930

20. Undertaker: C E Hickok
Address: Shoshone Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69282

PLACE OF DEATH
County of Lincoln
City of Richfield

Registration District No. 16
Primary Registration District No. 2016
(No. 7)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Hazle Jean Mary Downs

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Richfield Idaho
(State or country)

PARENTS

10. NAME OF FATHER Vern E. Downs
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Jean Marie Erwin
13. BIRTHPLACE OF MOTHER (city or town) Washington
(State or Country)

14. Informant Vern E. Downs
(Address) Richfield Idaho.

15. Filed Jan 29, 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Baby probably died from Convulsions
Father onset of Measles
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? History of Case
(Signed) J. L. Fuller, M. D.
..... 19... (Address) Shoshone

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, ~~or Removal~~	Date of Burial
Richfield	Jan 30 1930

20. Undertaker B. J. Brennan Shoshone
Address

RECEIVED FEB 8 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

J.L. Fuller
Shoshone, Idaho

Dear ~~Doctor~~ Sir:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. When the certificates are incomplete so they are unable to compile their statistics properly, they are returned to us with the request that we secure the information desired.

We are asking for some further information on the certificate mentioned below and enclose herewith an addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly cooperate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey

Special Agent, Bureau of Census.

In reference to the death certificate of:
Hazel Jean Marie Downs who died Jan. 29, 1930 at Richfield, Idaho, Lincoln county

Information DESIRED in order to complete certificate.

PLEASE STATE CAUSE OF DEATH AND HAVE CERTIFICATE SIGNED.

PLEASE ANSWER BELOW

From the history of case baby probably died from convulsions at the onset of Measles.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. FEB 7 1930 **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69283

Local Registrar's No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Madison

City of Sugar City

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Brent Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6. DATE OF BIRTH May 22 1924 (Month) (Day) (Year)

7. AGE 5 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sugar City Idaho

10. NAME OF Father John R. Peterson

11. BIRTHPLACE OF FATHER (State or Country) Teki Utah

12. MAIDEN NAME OF MOTHER Johannah Bancky

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia Peterson

(Address) Sugar City

15. Filed Feb 3 1930 Reyonn Local Registrar

MEDICAL CERTIFICATE OF DEATH 1926

16. DATE OF DEATH Jan. 31 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1930, to Jan 31 1930, that I last saw him alive on Jan 31 1930, and that death occurred on the date stated above, at 7:40 P M.

The CAUSE OF DEATH* was as follows:

Broken neck

Numerous fractures

of other bones

Automobile ran over deceased

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin C Rich M. D.

2/2 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER A E Eberseff | **ADDRESS**

FORM V. S. No. 5-25 M. 1-19. FEB 7 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69284

Local Registrar's No. 7

1. PLACE OF DEATH

County of Madison

City of Sugar City

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Robert Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M1

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: July 15 1919 (Month) (Day) (Year)

7. AGE: 9 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Sugar City Idaho

10. NAME OF Father: John R. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Lehi Utah

12. MAIDEN NAME OF MOTHER: Johannah Beverly

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Virginia Peterson
(Address) Sugar City Idaho

15. Filed Feb 3 1930 J. Rigoney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 31 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1930, to Jan 31 1930, that I last saw him alive on Jan 31 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fracture Base of Skull
numerous fractures of other bones

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Automobile ran over deceased

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis S. Rich M. D.

2/2 1930 (Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar

DATE OF BURIAL 19

20. UNDERTAKER: A. B. Eckersell

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 7 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

File No. 69285

Registered No. 6

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zella Meyrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: November 28 1886 (Month) (Day) (Year)

7. AGE: 43 yrs. 1 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Chester Utah

10. NAME OF FATHER: Alvin Allred

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Maria J. Barrison

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Meyrich

(Address) St. Anthony Idaho

15. Filed 1/23 1930 J Ryoung Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 23 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1930, to Jan 23 1930, that I last saw her alive on Jan 23 1930 and that death occurred on the date stated above, at 3:00 A M.

The CAUSE OF DEATH* was as follows:

(1) Fibroid Uteri
(2) Secondary anemia
(3) Uterine Haemorrhage

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Rigby M. D.

Jan 23 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilford Cemetery

DATE OF BURIAL: Jan. 26 1930

20. UNDERTAKER: W. M. Hansen

ADDRESS: St. Anthony Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. FEB 7 1930 CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. V 69286

Local Registrar's No. 5

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Elizabeth Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: July (Month) 19 (Day) 1860 ~~1930~~ (Year)

7. AGE: 69 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF Father: John Taylor.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Ann Harris

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W E Young

(Address) Rexburg, Idaho.

15. Filed 1/27 1930 J Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2-3 1930 to Jan 23 1930 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) arteriosclerosis with hypertension

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Farley Nelson M. D.

1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho, DATE OF BURIAL: 1/27/30 19

20. UNDERTAKER: A B Eckersell ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19. FEB 7 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Hibbard

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 69287

Local Registrar's No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arial Brown Oldham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: April 1 1903 (Month) (Day) (Year)

7. AGE: 26 Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dependant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF Father: Samuel Oldham

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary E. Brown,

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. P. Oldam

(Address) Rexburg, Idaho.

15. Filed 1/22 1930 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 22, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, to Jan 22 1930, that I last saw him alive on Jan 22 1930, and that death occurred on the date stated above, at 8:30 A M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Rigby M. D.

Jan 22 1930 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paradise, Utah.

DATE OF BURIAL: 1/24/30 19.....

20. UNDERTAKER: A. B. Eckersell

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69288

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 3

(No.) 161A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jean Thueson

(a) Residence, No. (Usual place of abode) Ashton, Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/11 — 30

7. AGE Years	Months	Days	If LESS than 1 day,
		11	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg

PARENTS

10. NAME OF FATHER Jean D. Thueson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Monroe Utah

12. MAIDEN NAME OF MOTHER Venice J. Cooper

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Casey Idaho

14. Informant Jean D. Thueson
(Address) Rexburg Idaho

15. Filed Jan 21, 1930 J. Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 21, 1930
that I last saw her alive on Jan 20, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows: Premature Birth

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Farley Nelson M. D.
Jan 21, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City, Idaho	1-21 1930
20. Undertaker	Address
Moore	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69289

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 2

(No. 1610)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Irene Thulson

(a) Residence. No. Ashton, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1-11-30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			4 hrs.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Rexburg Idaho

PARENTS

10. NAME OF FATHER Ivan D. Thulson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Monroe Utah
12. MAIDEN NAME OF MOTHER Venice J. Cooper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cardy Idaho

14. Informant Ivan D. Thulson
(Address) Ashton Idaho

15. Filed 1/12, 1930 Myrna Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 12, 1930
that I last saw her alive on Jan 11, 1930
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows: Premature (6½ mo.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Carley Nelson M. D.
Jan 12, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City	1-13 1930
20. Undertaker	Address
none	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69290

PLACE OF DEATH
County of Madison
City of Hibbard

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 1

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Inez Vera Parker

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sep. 9th 1901.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	4 Mo.		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hibbard.

PARENTS

10. NAME OF FATHER G. P. Parker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake. Ut.
12. MAIDEN NAME OF MOTHER Roda Lee.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake. Ut.

14. Informant G. P. Parker
(Address) Rex # 3.

15. Filed 1/10, 1930 J. Peyorra Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 5, 1930, to Jan. 9, 1930
that I last saw her alive on Jan 9, 1930
and that death occurred, on the date stated above, at 9:30 P m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Right Lung)
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. H. Ringler, M. D.
Jan 10, 1930 (Address) Hibbard Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Cem.	Jan 13 1930

20. Undertaker Thos. J. Keller Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69291

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

181B

2. FULL NAME Aaron John

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle John

6. DATE OF BIRTH (month, day and year) May 18, 1889

7. AGE Years 39 Months 7 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portage Ut.

PARENTS
10. NAME OF FATHER Levi John
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Wales
12. MAIDEN NAME OF MOTHER Ellen Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bever Utah

14. Informant Mrs Ellen John
(Address) Portage Utah

15. Filed 1-13, 1930 Ett Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan. 10, 1930
that I last saw him alive on Jan. 10, 1930
and that death occurred, on the date stated above, at 9:45 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms & history
(Signed) Ett Elmore, M.D.
1-13, 1930 (Address) Rupert. Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker D. C. Johnson | Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 502 M. 1-19. RECD FEB 6 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9303
Registered No. 30

1. PLACE OF DEATH
County of Nez Perce
City of Gifford
(No. ....., ... St.)
Registration District No. 92
Primary Registration District No. 2170
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman George Stellyes
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July (Month) 9 (Day) 1852 (Year)

7. AGE: 77 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Jozd Stellyes

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Metta Bolzer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry H Stellyes
(Address) Gifford Ida

15. Filed 1-23 1930 E E Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1930 (Year) 133

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1928 to Jan 22 1930 that I last saw him alive on Jan 15 1930 and that death occurred on the date stated above, at 1:30 P M.
The CAUSE OF DEATH* was as follows:
Cystitis
(Duration) 3 Yrs. 6 mos. ds.
Contributory (Secondary) Prostatitis
(Duration) 2 yrs. — mos. ds.
(Signed) E E Watts M. D.
1-23 1930 (Address) Gifford Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Good Hope — DATE OF BURIAL: 1-25 1930

20. UNDERTAKER: G. W. Brammer (ach) — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Scott RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69304

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mabel Whitcomb 46
(a) Residence. No. 4th Ave Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marvin Whitcomb
6. DATE OF BIRTH (month, day and year) —
7. AGE Years 39 Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Conway Wash
PARENTS
10. NAME OF FATHER John Parlett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Frances Cornell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa
14. Informant Marvin Whitcomb
(Address) Lewiston
15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Jan. 24, 1930
that I last saw her alive on Jan 24, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of cervix
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis Microscopical Exam
(Signed) R. T. Scott, M. D.
Jan 29, 1930 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida — Date of Burial: Jan 26 1930
20. Undertaker: Vassar Mortuary — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Johnson

DO NOT WRITE IN THIS SPACE
State File No. 69305

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 227 – Snakeriver Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Tid Alfred De Vault
(a) Residence. No. 227 – Snakeriver Ave. ~~St.~~
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan. 14 – 1930
7. AGE — Years — Months — Days 2 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho.

PARENTS
10. NAME OF FATHER J. K. De Vault
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Nancy Griffin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant John De Vault
(Address) Lewiston Idaho.
15. Filed Jan 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 16th 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930 to Jan 16, 1930
that I last saw him alive on Jan 14 (at birth), 1930
and that death occurred, on the date stated above, at a. m.
The CAUSE OF DEATH* was as follows:
Delicate new born baby sleeping with its mother who found it dead on waking at 5 a. m. Probably suffocation.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W. Johnson M. D.
1/16, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial 1/17 1930
20. Undertaker Brown Dunn & Address Lewiston Idaho

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69306

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Bushnell

(a) Residence. No. 1118 - 11th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6. DATE OF BIRTH (month, day and year): Apr 29 - 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	—	8	25 -	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spokane Wash.

PARENTS

10. NAME OF FATHER: Milo Bushnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wash
12. MAIDEN NAME OF MOTHER: Crystal Jackson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wash

14. Informant: Milo Bushnell
(Address) 1118 - 11th Ave Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: I was called after baby had been dead apparently several hours

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M - Lyle M. D.
1-27, 1930 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Jan 27 1930

20. Undertaker: Vassar Mortuary Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Causon
RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69308

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 112 - 16th Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

131

2. FULL NAME Letitia F Hopkins
(a) Residence. No. 112 - 16th Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) ✓

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ J P Hopkins

6. DATE OF BIRTH (month, day and year) Aug 29 - 1878

7. AGE Years 51 Months 4 Days 28 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Patrick Corrigan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Leath Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J P Hopkins
(Address) 112-16th ave Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1929, to Jan 27th, 1930
that I last saw her alive on Jan 27th, 1930
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:

Uremia
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis
(duration) ___ yrs. + mos. ___ ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & physical
(Signed) O C Carnagan M. D.
Jan 29th, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial 1/30 1930

20. Undertaker Vassar Mortuary
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69309

PLACE OF DEATH
County of Nez Perce
City of Lewiston Id. Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. FULL NAME Premature birth Love

(a) Residence. No. 2812-main St. Lewiston Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 29-1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Premature Birth
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Gregory Love
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Marianna Boggi Mrs Maggi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Gregory Love
(Address) Lewiston Idaho

15. Filed Jan 1 1930 Miriam E Brine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h[illegible] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 1 19 m.

The CAUSE OF DEATH* was as follows: Premature birth at 6 mos.

(duration) yrs. 20 min. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Paul B Johnson, M. D.
Jan 29, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	1/31 1930
20. Undertaker	Address
Jacobs Mortuary	Lewiston

Clerk

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69310

PLACE OF DEATH

County of Nez Perce

~~City of~~ Lapwai Tammany

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Michael Coover Pearson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 4th 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work U.B. Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Henry Pearson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penna.

12. MAIDEN NAME OF MOTHER — Williamson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Nellie Cox
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930. Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Jan 16, 1930
that I last saw h. alive on Jan 14, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Bronchio-pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W D Clark M. D.
1/16, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Near Myrtle Idaho.	1/17 1930

20. Undertaker Brower-Munn Co. Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Carsow

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69311

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 131

2. FULL NAME Gerald Carlton
(a) Residence. No. Juliaetta Idaho St. Juliaetta Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Oct, 16, 1920
7. AGE Years 9 Months 2 Days 28 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Juliaetta

PARENTS
10. NAME OF FATHER Marshall Carlton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.
12. MAIDEN NAME OF MOTHER Caroline Hutchinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Juliaetta Idaho

14. Informant M. Carlton
(Address) Juliaetta Idaho.
15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1 (Month) 14 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 6th, 1930, to Jan 14th, 1930
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Acute Nephritis
Parenchymatous
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? Kendrick Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Laboratory Tests
(Signed) O. Carsow, M. D.
Jan 18th, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 1/16 1930
20. Undertaker Vassar Mortuary Inc.
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69312

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. M White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Lester Lincoln Putnam

(a) Residence. No. St. Genesee, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

117

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 12 - 1911

7. AGE: 17 Years | Months: 11 | Days: 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Highschool Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Genesee Idaho

PARENTS

10. NAME OF FATHER: E. E. Putnam
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minn.
12. MAIDEN NAME OF MOTHER: Laura Archibald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn.

14. Informant: E. E. Putnam
(Address) Genesee Idaho

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 23rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 23, 1930
that I last saw him alive on Jan 23, 1930
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:
Acute Gangrenous appendicitis with General peritonitis
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 12-30
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms Bill
(Signed) E. L. White, M. D.
1 25, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Genesee, Idaho | Date of Burial: 1 25 1930

20. Undertaker: Mower - Dunn E. Lewiston, Idaho | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69313

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 129

2. FULL NAME Karl Baldus
(a) Residence. No. Nez Perce Idaho St. Nez Perce Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) ~~Married~~ Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Baldus
6. DATE OF BIRTH (month, day and year) May 9 1856
7. AGE Years 73 Months 8 Days 22 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER dont know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Ben Baldus
(Address) Nez Perce Idaho
15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 31st (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1929, to Jan 31st, 1930
that I last saw him alive on Jan 31st, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Chr Interstitial Nephritis
(duration) + yrs. mos. ds.
CONTRIBUTORY (Secondary) arteriosclerotic
(duration) + yrs. mos. ds.
18. Where was disease contracted if not at place of death? Spokane Wash
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Laboratory & Physical Examination
(Signed) O C Lawson M. D.
Feb 1st, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nez Perce Idaho
Date of Burial 2/3 1930
20. Undertaker Vassar Mortuary Inc
Address Lewiston Ida

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Johnson

DO NOT WRITE IN THIS SPACE

State File No. 69314

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Mabel Elizabeth McKinney

(a) Residence. No. 1318 — 10th ave St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Fred McKinney

6. DATE OF BIRTH (month, day and year) 9/27/1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	3	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Edward S. Sweet

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Elizabeth Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Fred McKinney

(Address) Lewiston, Idaho

15. Filed J 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 7th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw her alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Found dead in bed.)

(Had organic heart disease).

several years (duration) yrs. mos. ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted — if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul W. Johnson M. D.

1/8, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho	1/9 1930

20. Undertaker Brower-Warner Co. Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

PLACE OF DEATH

County of Nezperce

City of Lewiston,

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69315

Local Registrar's No.

131

2. FULL NAME Edna Berry

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George L Berry

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	9		hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Craigmont, Idaho

PARENTS

10. NAME OF FATHER J L Shinn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Nora Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant George L Berry, (Husband)
(Address) 409 Snake River Ave, Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930 to Jan 19, 1930

that I last saw h- alive on Jan 19, 1930

and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Uremia -

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Nephritis 2

Pregnancy, (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 18, 1930

Was there an autopsy? No

What test confirmed diagnosis? Physical & Lab. findings

(Signed) [illegible] M. D.

Jan 27/30 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ida Clarkston Wash.	1/21/30 19

20. Undertaker	Address
H.R.Merchant	Clarkston

Braddock.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69316

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

HH

2. FULL NAME J. A. Schultz.

(a) Residence, No. 612 - 4th St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Schultz.

6. DATE OF BIRTH (month, day and year) Feb 20 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	10	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Banker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER August Schultz.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Fred Schultz
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Brune Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Jan 13, 1930
that I last saw h was alive on Jan 13, 1930
and that death occurred, on the date stated above, at 11:45 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X Ray & Gastric analysis
(Signed) E W Brunam, M. D.
Jan 14, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	1/15 1930
20. Undertaker Cassaday Mortuary	Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69317

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

11B

2. FULL NAME Clara Francis LaDue

(a) Residence. No. 819-6th Ave Lewiston Ida. St. Walla Walla, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 31, 1854

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elgin Ill.

PARENTS

10. NAME OF FATHER Geo. E. Church
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y. State
12. MAIDEN NAME OF MOTHER Alice Burton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs. E. L. Alford
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 15th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 15, 1930
that I last saw her alive on Jan 15, 1930
and that death occurred, on the date stated above, at 6 33 P m.
The CAUSE OF DEATH* was as follows:

Influenza

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
Jan 16, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Walla Walla Wn. Date of Burial: 1/17 1930

20. Undertaker: Brower-Warne Co. Address: Lewiston Idaho

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69318

PLACE OF DEATH
County of Nez Perce
City of Lewiston Ida

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1010

2. FULL NAME G W Sutton

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer County farm Alabama

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Sister of St Joseph
(Address) Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1920, to Jan 20, 1930, that I last saw him alive on Jan 20, 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G W Sutton M. D.
1-29 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	1/22 1930

20. Undertaker Vassar Mortuary Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Ly C.

DO NOT WRITE IN THIS SPACE
State File No. 69319

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME William Jordan

(a) Residence. No. Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) dont know

7. AGE Years 78 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ✓ dont know

PARENTS
10. NAME OF FATHER ✓ —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ —
12. MAIDEN NAME OF MOTHER ✓ —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓ —

14. Informant Vassar Mortuary
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Brun
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 11, 1930
that I last saw him alive on Jan 11, 1930
and that death occurred, on the date stated above, at 10-30 am.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
1-13, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 1/14 1930

20. Undertaker Vassar Mortuary Inc.
Address Lewiston Idaho

Cannon

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69320

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

201

2. FULL NAME Janet C Baldeck
(a) Residence. No. 817 - 3rd st St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Baldeck.
6. DATE OF BIRTH (month, day and year) Jan. 14 1894
7. AGE Years 35 Months 11 Days 26 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS
10. NAME OF FATHER W J Pentland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Margaret Davidson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Joe Baldeck
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1930, to Jan 11th, 1930
that I last saw her alive on Jan 11th, 1930
and that death occurred, on the date stated above, at 3 p m.
The CAUSE OF DEATH* was as follows:
Fell down cellar stairs striking head on concrete floor
Basal Fracture of Skull
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Accident
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Hemmorrhage from tars
(Signed) D C Cannon M. D.
1/14th, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 1/13 1930
20. Undertaker Vassar Mortuary Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69320

Dr. O.C. Carssow
Lewiston, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Janett Baldeck who died at Lewiston, Idaho on Jan. 11, 1930
Cause of death given as "Basal Fracture of skull. Accident"

Information DESIRED in order to complete certificate:

WILL YOU PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH? IF AN AUTO WAS INVOLVED WILL YOU PLEASE STATE WHERE THE ACCIDENT OCCURRED?

PLEASE ANSWER BELOW:

Fell down cellar stairs striking head on concrete floor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69321

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Alri Clark Irwin.

(a) Residence. No. St. Portland, Oregon.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known.

7. AGE: 32. Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Not known.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known.

PARENTS

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant R. B. Wann
(Address) Lewiston, Idaho.

15. Filed Feb. Jun 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31st, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to Jan 31, 1930.
that I last saw him alive on Jan 31, 1930.
and that death occurred, on the date stated above, at 9 30 a. m.
The CAUSE OF DEATH* was as follows:

Uremic Convulsions.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Urine

(Signed) William [illegible], M. D.

2/1/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 2/6/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Ida.

RECEIVED FEB 4 1930

PLACE OF DEATH

County of .....

City of .....

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69322

Registration District No. 26

Primary Registration District No. 2064

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Sarah Fern Daniels

(a) Residence. No. Malad Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 26 1911

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18	1	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Malad, Idaho

PARENTS

10. NAME OF FATHER: Daniel M. Daniels

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Brigham City, Utah

12. MAIDEN NAME OF MOTHER: Catherine Elizabeth Owens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Malad, Ida.

14. Informant: Mrs Russel Daniels
(Address) Malad Ida

15. Filed 1/31, 1930 J. M. Kerns
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan - 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 23, 1930

that I last saw her alive on Jan 22, 1930

and that death occurred, on the date stated above, at 5:15 a m.

The CAUSE OF DEATH* was as follows:
Epidemic Spinal meningitis

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Spinal Puncture

(Signed) [signature] M. D.

1/26, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida

Date of Burial: Jan 25 1930

20. Undertaker: J. Guy Benson

Address: Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69323

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2064
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Glenn Lewis Jundell 40

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 16 - 1929

7. AGE Years | Months 3 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Ida

PARENTS

10. NAME OF FATHER Dwight H. Jundell
11. BIRTHPLACE OF FATHER (city or town) Woodruff
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Violet Elizabeth Lewis
13. BIRTHPLACE OF MOTHER (city or town) Malad
(State or Country) Idaho

14. Informant Dwight H Jundel
(Address) Malad Ida

15. Filed 1/31, 1930 J. M. Kerns
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ at birth, 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Convulsions from strangulated hemid. Did not see baby before death.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) V. P. Garst, M. D.
Jan. 22 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John. | Date of Burial Jan 22 1930

20. Undertaker J. Guy Benson | Address Malad Ida

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69324

PLACE OF DEATH

County of Oneida

City of St John

Registration District No. 26

Primary Registration District No. 2069

Local Registrar's No. 5

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Mary ann Monson

(a) Residence. No. St John fifty three years St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of Hiram Monson

6. DATE OF BIRTH (month, day and year): Apr. 7 1869

7. AGE: Years 60 Months 9 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: farmers wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): willard utah

10. NAME OF FATHER: Louis Deschamps

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada

12. MAIDEN NAME OF MOTHER: ann M Stephens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): wakes willcreek utah

Informant: Andie Talbot

(Address) R F D #1 Malad Ida

Filed 1/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 16 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 years, 19..., to Jan 16, 1930

that I last saw her alive on Jan 15, 1930

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows: Cause of Nature extension to bowel.

..... (duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same

Did an operation precede death? yes no Date of April 1929

Was there an autopsy?

What test confirmed diagnosis? operation

(Signed) [signature] M. D.

1/20, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St John Ida — Date of Burial: Jan 20 1930

20. Undertaker: J. Guy Benson — Address: Malad Ida

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69325

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

48 B

2. FULL NAME Elizabeth Leigh Peck
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Fredrick Peck

6. DATE OF BIRTH (month, day and year) July 3. 1854

7. AGE Years 75 Months 6 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brigham Utah

PARENTS
10. NAME OF FATHER Daniel Leigh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Mrs Seth Thomas
(Address) Malad Ida

15. Filed 1/30, 1930 J. M. Kenner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 15 1930
Dec 31 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31, 1929, to Jan 15, 1930
that I last saw her alive on Jan 14, 1929
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Myocarditis
mitral insuf.
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [signature] M. D.
1/16, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial Jan 18 1930

20. Undertaker J. Guy Benson
Address Malad Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69326

PLACE OF DEATH
County of Ada
City of Malad

Registration District No. 26
Primary Registration District No. 269
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

144

2. FULL NAME Martishia Ellen Thomas Kent.

(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dalam Evan Kent.

6. DATE OF BIRTH (month, day and year) Jan. 18. 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad Ida

PARENTS

10. NAME OF FATHER Emmett H. Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Trade Tennessee
12. MAIDEN NAME OF MOTHER Martha Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Malad Ida

14. Informant Dalam E. Kent.
(Address) Malad Ida RFD #1

15. Filed 1/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Jan 10, 1930
that I last saw her alive on Jan 10, 1930
and that death occurred, on the date stated above, at 4.9 m.
The CAUSE OF DEATH* was as follows:

Hypostatic Suppuration
Ectopic Gestation.
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Kerns, M. D.
1/10, 1930 (Address) Malad

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	Jan 13 1930

20. Undertaker	Address
J. Guy Keenan	Malad Ida

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26

Primary Registration District No. 2069

(No. ..... St.)

File No. 69327

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cyril J. Call.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: July (Month) 4 (Day) 1849 (Year)

7. AGE: 80 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Josiah Call

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Henrietta Williams

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laurence Call

(Address) Malad Ida

15. Filed 1/31 1930

J. M. Kerns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1929, to Jan 2 1930 that I last saw him alive on Jan 2 1930 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows: Myocarditis following pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) [signature] M. D.

1/2 1930 (Address) Malad Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. John Ida

DATE OF BURIAL: Jan 5 1929

20. UNDERTAKER: J. Guy Benson

ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of [illegible]

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED FEB 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 6928
Registered No. 2

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Ann Bywater Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1858 (Year)

7. AGE: 71 Yrs. 7 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake Cy, Utah.

10. NAME OF FATHER: James Bywater

11. BIRTHPLACE OF FATHER (State or Country): Holbeck, England

12. MAIDEN NAME OF MOTHER: Maria Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Glanmorganshire, ~~Glamorganshire~~, Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. B. Jones
(Address) Malad, Idaho

15. Filed 1/31 1930 J. M. Kerns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 2 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1929 to Jan 2 1930
that I last saw h[er] alive on Jan 2 1930
and that death occurred on the date stated above, at 3:30a M.

The CAUSE OF DEATH* was as follows:
Endocarditis, Senility
Coma 2 hrs.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Coma 2 hrs.
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
1/2 1930 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Cem. DATE OF BURIAL: Jan. 6 1930

20. UNDERTAKER: J. Guy Benson ADDRESS: Malad Cem

RECEIVED FEB 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69329

PLACE OF DEATH
County of Kootenai
City of Hayden Lake
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 5
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Pascal Johnson. 74a

(a) Residence. No. Hayden Lake Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Martha J. Johnson

6. DATE OF BIRTH (month, day and year) 1/7/1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	✓	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cattleman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wheatown Seminole.

PARENTS

10. NAME OF FATHER Nathan Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dent Sarcey
12. MAIDEN NAME OF MOTHER Nancy English
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dent Sarcey

14. Informant Mrs. R. S. Estey
(Address) Hayden Lake Ida

15. Filed 1-17-, 1930. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to , 19
that I last saw h~~is~~ alive on Jan 11, 1930
and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Robert E Talbot, M. D.
Jan 20, 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	1/17 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69330

PLACE OF DEATH

County of Cuyhne
City of —

Registration District No. 7
Primary Registration District No. 2006
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

90

2. FULL NAME Joseph A Walker
(a) Residence No. Gwens Spgs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 74 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work P. M.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Kenneth Walker
(Address) Wilson Ida

15. Filed 1-13, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 11, 1930
that I last saw him alive on Jan 10, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Mitral regurgitation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W C Wolf MD M. D.
1/13, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wilson Ida | Date of Burial 1-14 1930

20. Undertaker F. K. Robinson | Address Nampa Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69331

PLACE OF DEATH
County of Owyhee
City of Bruneau

Registration District No. 34
Primary Registration District No. 2020
(No. _____)
Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Frank Wheelock Riddle

(a) Residence. No. _____ St. _____
(Usual place of abode)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Delia N. Riddle

6 DATE OF BIRTH (month, day and year) 8-31-1858

7 AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
71	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS
10 NAME OF FATHER Reuben P. Riddle
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.
12 MAIDEN NAME OF MOTHER Hetty A. Palmer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mich.

14 Informant Mrs. F. W. Riddle
(Address) Bruneau, Idaho.

15 Filed 2/11, 1930. _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 1st (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1930, to Jan. 1, 1930, that I last saw him alive on Jan 1, 1930, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:
Angina pectoris -
(duration) 10 yrs. _____ mos. _____ ds.
CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) 10 yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? _____

(Signed) G. C. Hamilton, M. D.
Jan. 2, 1930 (Address) Mtn. Home Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Boise - Idaho.	1-6 1930

20. Undertaker G. S. Barker — Address Mt. Home Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69332

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power
City of American Falls,

Registration District No. 25
Primary Registration District No. 2072
(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 2

101a

2. FULL NAME Rhuby Lunz

(a) Residence. No. ..... St. Aberdeen, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John J. Lunz

6 DATE OF BIRTH (month, day and year): May 26th - 1885

7 AGE: Years 44, Months 8, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): House wife
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10 NAME OF FATHER: James Rruby
11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia
12 MAIDEN NAME OF MOTHER: Maree Fritz
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs Arthur Kunkel
(Address) 8333 Dibble Ave N.W. Seattle, Wash

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jany (Month) 27th (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 27, 1930, that I last saw her alive on Jan 26, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Empyaemia of chest - Erysipelas of face - 5 days
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Jan 24 - 26 & 27
Was there an autopsy? no
What test confirmed diagnosis? Sputum examined.
(Signed) M. C. McKinnon, M. D.
1-27, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Aberdeen, Idaho
Date of Burial: 1-29 1930

20. Undertaker: Arv Davis
Address: American Falls Ida

RECEIVED FEB 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69333

PLACE OF DEATH

County of Power

City of American Falls, Idaho

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Hildor Kay Johnson

(a) Residence. No. Brigham City, Utah St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Otto Alfred Johnson

6 DATE OF BIRTH (month, day and year): Jan 6th 1857

7 AGE: Years 73 | Months 0 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10 NAME OF FATHER: Bryant Hans Kay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway

12 MAIDEN NAME OF MOTHER: Anna Ingelbretson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norway

14 Informant: J Henry Moss
(Address) American Falls, Idaho

15 Filed Jan 2[illegible], 1930 Genevieve North Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jany (Month) 22nd (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Dont know. Did not see party untill after death

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. G. Logan, M. D.

1/23/30, 19..... (Address) Am Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Salt Lake City, Uth

Date of Burial: ~~1/23/30~~

20. Undertaker: [illegible]

Address: AmericanFalls, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. A-25M. 1-19.

RECEIVED FEB 15 19

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69334

Local Registrar's No. 10

Registration District No. 70

Primary Registration District No. 1011

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
(No. 81 River St. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marilyn Elaine Mosiman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word):

6. DATE OF BIRTH: Dec. (Month) 28 (Day) 1928 (Year)

7. AGE: 2 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wallace Idaho

10. NAME OF Father: Robert R. Mosiman

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Marian Michels

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert R Mosiman
(Address): Wallace Ida

15. Filed Jan 31 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

177

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1930 to Jan 30 1930
that I last saw her alive on Jan 30 1930
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia Poisoning
(Duration) ....yrs. ....mos. 2 ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) Wm. J. Smith M. D.
1/31/30 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Joseph, Mo. DATE OF BURIAL: 1-31 1930

20. UNDERTAKER: Bruce G. Worstell ADDRESS: Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 15 1930

FORM V. S. No. 5-A-20M. 4-29.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1016
(No. Wallace Hospital St.)

State File No. 69335
Local Registrar's No. 9
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Axel Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: November 19th 1881 (Month) (Day) (Year)

7. AGE: 48 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF Father: Not known

11. BIRTHPLACE OF FATHER (State or Country): ✓ ✓

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur M Jessup
(Address) Wallace Idaho

15. Filed Jan 26 1930 L. K. Knight Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: Jan 24 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-20-29 19.. to 1-24 1930, that I last saw h alive on 1-23 1930 and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Pulmonary and
Abdominal Tuberculosis

(Duration) 1 yrs. .... mos. .... ds.

Contributory (Secondary)
(Duration) .... yrs. .... mos. .... ds.

(Signed) Wm T. Smith M. D.
19.. (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mullan Ida — DATE OF BURIAL: Jany 26 1930

20. UNDERTAKER: J. G. Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69336

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 20
Primary Registration District No. 1011
(No. 20 Infirmary)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

1011a

2. FULL NAME Clinton Silvis

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Tamarack Mug Co.

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Tony Mottetti
(Address) Wallace Idaho

15. Filed Jan 25, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 22 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Oct 29, 19[illegible], to Jan 22, 1930
that I last saw him alive on Jan 22, 1930
and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Valv. Heart

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James R Kean, M. D.

1/22, 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	Jan 25 1930
20. Undertaker J. G. Beer	Address
Ward and Co	Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6933 31

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1914
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

101a

2. FULL NAME Dennis Sullivan

(a) Residence. No. Burke, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Burke, Idaho.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Mary Sullivan

6. DATE OF BIRTH (month, day and year) Nov-28-1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	1	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hercules Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Jeremiah Sullivan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Ellen Leary

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs Mary Sullivan
(Address) Burke, Idaho

15. Filed Jan 21, 1930. L. E. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 16, 1930, that I last saw h~~er~~ alive on Jan 16, 1930, and that death occurred, on the date stated above, at 1:A m.

The CAUSE OF DEATH* was as follows: Pneumonia lobular all lobes both lungs

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. Several mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr H Howard, M. D.

1/17, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash.	Jan 21 1930

20. Undertaker J.A. Bever Ward Lund Co. Address Wallace Idaho

FORM V. S. No. 6-A-28M. 1-1

RECEIVED FEB 15 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69338

Local Registrar's No. 6

1. PLACE OF DEATH

County of Shoshone

City of Mullan Ida.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug (Month) ..... (Day) 1885 (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer Railroad
(b) General nature of industry, business or establishment in which employed (or employer): M. P.

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF Father

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto C. Behnke
(Address) Garrison Montana

15. Filed Jan 17 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH 189a

16. DATE OF DEATH: Jan (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1930, to Jan 16 1930, that I last saw him alive on Jan 16 1930, and that death occurred on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Burn of body and inhalation of steam, Railway accident - derailed engine

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Quigley M. D.

Jan 17 1930 (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: 1-17 1930

20. UNDERTAKER: Irwin G. Worstell ADDRESS: Wallace Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

RECEIVED FEB 15 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69339

Local Registrar's No. 5

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. M. Harrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: May (Month) 9 (Day) 1887 (Year)

7. AGE: 42 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Owner
(b) General nature of industry, business or establishment in which employed (or employer): Mine Owners Association

9. BIRTHPLACE (State or Country): Denver Colorado

10. NAME OF Father: Nania M. Harrington

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margret Gleeson

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Harrington
(Address) Denver Colorado

15. Filed Jan 17 1930 F. R. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH: Jan. (Month) 14th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1929, to Jan 14th 1930, that I last saw him alive on Jan 14th 1930 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Sub-Dural) (Traumatic) Accident

(Duration) ..... yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Max T. Smith M. D.

19 (Address) Wallace, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Colorado

DATE OF BURIAL: 1-17 1930

20. UNDERTAKER: Irene G. Norstell

ADDRESS: Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69340

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

88B

2. FULL NAME Lena Mattila
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Oscar Mattila

6. DATE OF BIRTH (month, day and year) Jan 20 - 1888

7. AGE Years 41 Months 11 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Oscar Mattila
(Address) Wallace, Idaho.

15. Filed Jan 13, 1930. H. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 12, 1930
that I last saw her alive on Jan 12, 1930
and that death occurred, on the date stated above, at 1545 P.M.
The CAUSE OF DEATH* was as follows:
Myocarditis
Chronic
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Alcoholism
Several months (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Mowry Corone M. D.
1/13 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho
Date of Burial Jan 13 1930

20. Undertaker J. G. Bever Ward Wood Co.
Address Wallace, Ida.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69341

Local Registrar's No. 3

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 2011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

5-60

2. FULL NAME Hugh McGillis

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~

6. DATE OF BIRTH (month, day and year) May 16 - 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	7	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario Canada

PARENTS

10. NAME OF FATHER Donald McGillis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Anna McDougald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario Canada

14. Informant Mrs Wm Wilkins
(Address) Wallace Idaho

15. Filed Jan 12, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Jan 11, 1930
that I last saw him alive on Jan 10, 1930
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
8
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
1/14/30, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	Jan 13 1930
20. Undertaker J. A Bever	Address
Ward Und. Co.	Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69342

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1016
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 2

2. FULL NAME Chas R. Couch

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 12 - 1919

7. AGE	Years	Months	Days	If LESS than 1 day,
	9	11	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho

PARENTS

10. NAME OF FATHER Chas Couch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Fannie Pitt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ills.

14. Informant Chas Couch
(Address) Wallace, Idaho.

15. Filed Jan 5, 1930 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 3, 1930
that I last saw h ins alive on Jan 3, 1930
and that death occurred, on the date stated above, at 12:15 A m.
The CAUSE OF DEATH* was as follows:
Brain abscess
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Jan 3 1930
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur C. Jordan M. D.
Jan 4, 1930 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Jan 5 1930
20. Undertaker	Address
Wark Funl Co.	Wallace, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69343

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 1

(No. Providence Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Joan Marie Bernardi

(a) Residence No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3 - 30

7. AGE Years Months Days If LESS than 1 day, 4 hrs. hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10. NAME OF FATHER Joseph Bernardi

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Black Bear Idaho

12. MAIDEN NAME OF MOTHER Mildred Drake

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash.

14. Informant Mrs A. Albertina

(Address) Wallace, Idaho.

15. Filed Jan 4, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 3 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows: Premature 7 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Mowery M. D.

73, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Jan 4 1930

20. Undertaker Jas. Bever Ward Und Co. Address Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69356

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 8

(No. 7 Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME William Parker Swinerton

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Widowed Agnes Swinerton

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77	8	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Road Overseer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Toronto (State or country) Canada

PARENTS

10. NAME OF FATHER Thomas Swinerton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Eliza Parker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Albert Swinerton
(Address) Kellogg, Idaho

15. Filed Jan. 20, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928 to Jan 18, 1930
that I last saw him alive on Jan 18, 1930
and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage from bladder (probably cancer)

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. H. Kennett, M. D.
Jan 19, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg, Idaho	Jan 21 1930

20. Undertaker J. A. Beaver Address
Ward Und. Co. Wallace, Idaho

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69357

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 7
161a

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Melise

(a) Residence. No. Kellogg Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 30 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Ida

PARENTS

10. NAME OF FATHER Peter Melesi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Genevieve Leonesio
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Peter Melesi
(Address)

15. Filed Jan. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to January 15, 1930
that I last saw h alive on January 13, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Premature Birth
Vitality Poor.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. R. Musson, M. D.
1/28, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Ida	Jan 17 1930

20. Undertaker R. L. Stant
Address Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69358

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 1 2 3
Primary Registration District No. 1201
Local Registrar's No. 6

(No.) 71a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James William Shewmaker

(a) Residence. No. Deadwood Gulch, Kellogg Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 2 - 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	2	7	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg, Idaho

PARENTS

10. NAME OF FATHER Merritt F. Shewmaker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) St Joe Missouri

12. MAIDEN NAME OF MOTHER Dora Kelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butte Mont

14. Informant Mrs M. F. Shewmaker.
(Address) Kellogg Idaho.

15. Filed Jan. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jany (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jany 7, 1930, to Jany 9, 1930
that I last saw h[illegible] alive on Jany 8, 1930
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:

Meningitis following Pneumonia,
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. E. Mason M. D.
Jany 10, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Jan 12 1930
20. Undertaker M. C. Thornhill	Address Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69359

Registration District No. 123
Primary Registration District No. 3201
Local Registrar's No. 5

PLACE OF DEATH
County of Shoshone
City of Kellogg

(No.) 31
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ray Fennell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 18 - 1906

7. AGE: Years 23 | Months 2 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kellogg Ida

PARENTS
10. NAME OF FATHER: Wm Fennell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisconsin
12. MAIDEN NAME OF MOTHER: Hilda Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Wm Fennell
(Address): Kellogg Ida

15. Filed Jan. 30, 1930 Thos. Helen McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to January 6, 1930
that last saw h[illegible] alive on January 6, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? a

(Signed) J. C. Mason, M. D.
January 9, 1930 (Address) J. C. Mason Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida
Date of Burial: Jan 9 1930

20. Undertaker: R. L. Stout
Address: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC... FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69360

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. Mesley Maternity Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

1010

2. FULL NAME Genevieve Marion Malesi

(a) Residence. No. Pine Creek St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Malesi

6. DATE OF BIRTH (month, day and year) Oct 24 -

7. AGE	Years	Months	Days	If LESS than 1 day,
	35	2.	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS
10. NAME OF FATHER Pete Leonesio
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Leonesio
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant John Malesi
(Address) Kellogg Ida

15. Filed Jan. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Jany 3, 1930
that I last saw h~~er~~ alive on Jany 3, 1930
and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Gave birth to child Dec 31 - 29,
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exposure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. R. Nissen M. D.
Jany 9, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Ida	Jan 8 1930
20. Undertaker	Address
R. L. Stout	Kellogg Ida

RECEIVED FEB 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69361

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

2. FULL NAME Curson Charlton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 31, 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	48	11	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Allen Charlton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Louise Poindexter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Laura Petzdick
(Address) Kellogg Idaho

15. Filed Jan. 30, 1930 Mrs. Ellen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
January 3, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:
Heart trouble
Dead when Called
Permission to sign by Coroner H. Mowery
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? None.
(Signed) J. R. Meeson, M. D.
January 3, 1930 (Address) Kellogg. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrington Wash	John 4 1930
20. Undertaker	Address
M. C. Thornhill	Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69363

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Thomas Jos. Wye
(a) Residence. No. 2 Falls St. Rosser 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 5/29

7. AGE: 1 Years, Months 1, Days 24 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER H. E. Wye
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Mary Bryane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant H. E. Wye
(Address) Twin Falls

15. Filed February 8th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 29 1930 5:30 A.M.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 9, 1930, to Jan. 29, 1930
that I last saw him alive on Jan. 28, 1930
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:
Septicemia (Streptococcus erysipelatos)
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Erysipelas
(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death? Place of death.
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Clinical & Laboratory findings.
(Signed) N. F. Rosser M. D.
Jan. 29, 1930 (Address) Twin Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Jan 30 1930
20. Undertaker: D. C. Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69364

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Verna Campbell
(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100 a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) S

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 11 1928

7. AGE 1 Years 6 Months 18 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) No

PARENTS
10. NAME OF FATHER J. M. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER Sophia Boyle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant J. A. Campbell
(Address) Kimberly

15. Filed Feb. 8th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 29 1930 (Month) (Day) (Year) 6 oct.

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to Jan 29, 1930
that I last saw her alive on Jan 28, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kimberly Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & X-Ray
(Signed) J. N. Davis, M. D.
Jan-29, 1930 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery
Date of Burial Jan 30 1930

20. Undertaker T. E. Srok Twin Falls
Address

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69365

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101 B

2. FULL NAME Maria Guibert
(a) Residence. No. 219 - 3rd Ave N. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 14 - 1871

7. AGE: 59 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife - Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brussels Belgium

PARENTS
10. NAME OF FATHER Michiels
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brussels Belgium
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Worth William
(Address) 621 - N 7th St

15. Filed February 8th, 1930 Grand Junction Colo. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 29, 1930
that I last saw her alive on Jan 29, 1930
and that death occurred, on the date stated above, at 6 am m.
The CAUSE OF DEATH* was as follows: Croupous Pneumonia.
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Wilson, M. D.
Jan 31, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery | Date of Burial: Feb 1 - 1930

20. Undertaker: White Mortuary Inc | Address: Twin Falls, Idaho

WRITE PLAINLY,

N. B.—Every item of information should be carefully sup should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

ECORD

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69366

PLACE OF DEATH

County of Twin Falls.

City of Twin Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Clara America Rankin

(a) Residence. No. Hazelton Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11 - 1914

7. AGE Years: 15 Months: 5 Days: 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Okla

PARENTS

10. NAME OF FATHER: Edward Rankin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Ella Branham

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs. E. H. Wilson
(Address) Hazelton

15. Filed Feb. 8th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Jan 26, 1930 that I last saw her alive on Jan 26, 1930 and that death occurred, on the date stated above, at 49 m.

The CAUSE OF DEATH* was as follows:
Accidental - burns - Kerosene
Started fire in stone with Kerosene
Entire body burned.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ranch house near Hazelton, Idaho.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Lorschek, M. D.
Jan 26, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: 2-5-1930

20. Undertaker: White Mortuary Inc — Address: Twin Falls. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69367

PLACE OF DEATH
County Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 118

2. FULL NAME Jennie D Miller

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Alex Wilder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 8/1894

7. AGE 35 Years Months 3 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Frank Damals
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Ema Stanley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Emma Damals
(Address) Filer

15. Filed February 8th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1929, to Jan 21st, 1930
that I last saw him alive on Jan 21, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Obstruction intestinal mechanical (Secondary Toxemia)
(duration) yrs. mos. 10 hrs
CONTRIBUTORY (Secondary) Salpingitis chronic-pelvic peritonitis (duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Jan 15th
Was there an autopsy? Salpingectomy (Jan 21 - Sleostomy and relief of obstruction)
What test confirmed diagnosis? Operation
(Signed) [illegible], M. D.
1-24, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Jan 24 1930

20. Undertaker T E Drake
Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69368

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME Gilbert Dale McClain

(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar "17

7. AGE: 3 Years | Months: 10 | Days: 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER C. F. McClain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark
12. MAIDEN NAME OF MOTHER Mable Hanks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark

14. Informant C. F. McClain
(Address) Twin Falls

15. Filed Feb. 8th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Jan 28, 1930
that I last saw him alive on Jan 18, 1930
and that death occurred, on the date stated above, at 4 p m.
The CAUSE OF DEATH* was as follows:
Acute Dilation of heart
Broncho-pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John Langhelm M. D.
1-22, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Jan 23 1930

20. Undertaker: T. E. Drake | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69369

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby St. John
(a) Residence. No. (Usual place of abode) St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER N. E. St John
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Lucy Fales
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant N. E. St John
(Address) Twin Falls

15. Filed Feb. 8th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

still birth - abruptio placentae

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Charles R. Scott, M. D.
Jan. 29, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Jan 30 1930
20. Undertaker J. E. Funk	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69370

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100 0

2. FULL NAME Mary Ellen Payton

(a) Residence. No. Twin Falls Ida R.R.#1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Twin Falls Ida

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER John Payton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mildred Canfield

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebr.

14. Informant John Payton
(Address) Twin Falls Ida R.R.#1

15. Filed Feb 8th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3rd 1930, to Jan 5th 1930, that I last saw her alive on Jan 4th 1930.
and that death occurred, on the date stated above, at 330 P.m.
The CAUSE OF DEATH* was as follows: Bilateral Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? "
Did an operation precede death? No Date of "
Was there an autopsy? No What test confirmed diagnosis? Clinical signs

(Signed) John F. Templeton M. D.
1-8 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida — Date of Burial: Jan 7 1930

20. Undertaker: P. J. Grossman — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69371

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

155

2. FULL NAME Evert Griffard

(a) Residence. No. 331 - 3rd Ave W. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 19 - 1915

7. AGE Years: 14 Months: 0 Days: 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) American Falls, Ida

PARENTS

10. NAME OF FATHER Virece G. Griffard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Grace Waltman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Virece G. Griffard
(Address) 331 - 3rd Ave W.

15. Filed February 8th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Jan 3, 1930
that I last saw him alive on Jan 3, 1930
and that death occurred, on the date stated above, at 2P m.
The CAUSE OF DEATH* was as follows:
Osteomyelitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec 27-1929
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. W. Glauchek, M. D.
Jan 3, 1930. (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: Jan 5 1930

20. Undertaker: White Mortuary Inc — Address: Twin Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

RECEIVED FEB 10 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69372

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Kimberly,
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

2. FULL NAME Lloyd Eugene McDrummond,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	single

6. DATE OF BIRTH: April (Month) 13 (Day) 1929 (Year)

7. AGE: Yrs. 9 Mos. 6 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country) Kimberly, Idaho

10. NAME OF Father: Harvey McDrummond

11. BIRTHPLACE OF FATHER (State or Country) Okla.

12. MAIDEN NAME OF MOTHER: Pearl Plew

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey McDrummond
(Address) Kimberly, Idaho

15. Filed Jan - 30th 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 19 (Day) 10 a.m. 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr.13 1929 19..., to Jan.19,1930 19..., that I last saw him alive on Jan.19,1929 19..., and that death occurred on the date stated above, at 1½ P.M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ...yrs. ...mos. 1 ...ds.

Contributory (Secondary) Marasmus and Meglacolcn.

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. M. Dawis M. D.

1/30 1930 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls DATE OF BURIAL: Jan 30 1930

20. UNDERTAKER J. E. Dark ADDRESS Twin Falls

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 60373

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
Local Registrar's No. 1015
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Foley

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 3 1851
7. AGE: Years 78 | Months 6 | Days 7 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Railway Worker
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Penn
PARENTS
10. NAME OF FATHER: — Foley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown
14. Informant: Mrs Almquist
(Address): Twin Falls
15. Filed 1-30, 1930 Registrar: Eugene J. Smith

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 10 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1 st, 1930, to Jan 10th, 1930
that I last saw him alive on Jan 10, 1930
and that death occurred, on the date stated above, at 8:20 m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) C A Sivers, M. D.
1-11, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Jan 13 1930
20. Undertaker: J C Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69374

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. 245 6th Ave N)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME S S Dell

(a) Residence. No. 245 6th Ave N St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 14 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Druggist
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) M S

PARENTS

10. NAME OF FATHER Edward Dell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Alberta Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Mrs S S Dell
(Address) Twin Falls

15. Filed 1-30, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Died Unattended on Street
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Careful examination revealed that death
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? was due to
Did an operation precede death? Date of
Was there an autopsy? Cardiac Insufficiency
What test confirmed diagnosis?
(Signed) F E Yoakum Coroner M. D.
..., 19... (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls | Date of Burial Jan 22 1930
20. Undertaker F E Yoakum Address Twin Falls

RECEIVED FEB 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69375

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

Warner
162

2. FULL NAME Cleta Lenora Gilman

(a) Residence. No. 940 - 4th W. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 19 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls
(State or country) Ida

PARENTS

10. NAME OF FATHER Claude W. Gilman
11. BIRTHPLACE OF FATHER (city or town) Boulder
(State or Country) Colorado
12. MAIDEN NAME OF MOTHER Ada Wilson
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mo.

14. Informant Mrs. W. H. Gilman
(Address) Twin Falls. Ida.

15. Filed 1-30, 1930 Elizabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 20, 1930
that I last saw h[illegible] alive on 19
and that death occurred, on the date stated above, at 9 20 a m.

The CAUSE OF DEATH* was as follows:
Status Lymphaticus

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) W. Russell Warner M. D.
Jan 20, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	1-21, 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

69342

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69382

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. B 40
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Rose, L Dexter

(a) Residence. No. 1317 Grove St.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 27 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	4	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Barney Bletcher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Welthy Julia Strong
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Frank B. Leonard
(Address) Jarbidge Nevada

15. Filed 2-10 1930 W. N. Rhodes Registrar
R. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2-1, 1930, to 2-6, 1930
that I last saw her alive on Feb 6, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Labar Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. McCallum M. D.
2/7 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 9 1930
20. Undertaker	Address
Summers & Kibbe	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

69383

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 8

DO NOT WRITE IN THIS SPACE

State File No. 69383

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. .....

Primary Registration District No. 2004 Local Registrar's No. .....

(No. 5 Miles East of Boise.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. **FULL NAME** Ray Adair.

(a) Residence. No. 5 Miles of Boise. St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) June 30th 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	7	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk, Grocery Store.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Greenriver, Utah.

PARENTS

10. NAME OF FATHER Thomas Ray Adair.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dumis, Mo.

12. MAIDEN NAME OF MOTHER Etta Murphy.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Thisle, Utah.

14. Informant (Address) Mrs. Etta Bedal. Boise, Idaho.

15. Filed 2-18-30, 19 W. J. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 17th 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19--, to ----------, 19.. ~~that I last saw him alive on~~ ----------, 19.. and ~~that~~ death occurred, on the date stated above, at about 8 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Shot himself with 12 Gauge Shotgun. Shot entered body about 1 inch below heart. Death was instantaneous (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Suicide

No Inquest held. (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of ---

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) Wm McBratney Coroner ~~M. D.~~

2/18/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/19/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

69384

DO NOT WRITE IN THIS SPACE

State File No. 69384

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1904

Local Registrar's No. 57

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Carl Thiel

(a) Residence. No. 224 E Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Thiel

6. DATE OF BIRTH (month, day and year) Nov. 2.-1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	3	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician & Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hannibal Mo

PARENTS

10. NAME OF FATHER John H Thiel

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cincinatti Ohio

12. MAIDEN NAME OF MOTHER Cordelia Thomas

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs J. Carl Thiel

(Address) 224 E Idaho St Boise Idaho

15. Filed 2-20 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 (Month) 6 PM (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1930 to Feb 18 1930

that I last saw him alive on Feby 18 1930

and that death occurred, on the date stated above, at 6 PM

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

Streptococcemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Ida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James L Elwood, M. D.

2/19/30 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 21 1930
20. Undertaker	Address
Summers & Trebs	Boise Idaho

69385

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69385

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.)

Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

90

2. FULL NAME Warner Hunter Carithers

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 11, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work M.D.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bloomington Ill.

PARENTS

10 NAME OF FATHER W.B. Carithers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chic

12 MAIDEN NAME OF MOTHER Sarah Foraker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chic

14 Informant Mrs. W.H. Carithers
(Address) Moscow, Ida.

15 Filed 2/4, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 2, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to Feb. 2, 1930, that I last saw h[illegible] alive on Feb. 2, 1930, and that death occurred, on the date stated above, at 3:50 P m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis.

(Duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis & hypertension.

about 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Electrocardiograph

(Signed) Stacy Cathcart, M. D.

2/3, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of ~~Burial~~ Cremation, or ~~Removal~~ Spokane, Wash. Date of Burial 2/5/30 19

20. Undertaker H.R. Short Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

69386

DO NOT WRITE IN THIS SPACE
State File No. 69386

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 21
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Daniel Dunnigan.

(a) Residence. No. Rural St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Dunnigan

6. DATE OF BIRTH (month, day and year) Aug 11, 1868

7. AGE: Years 61 | Months 6 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mayo Quebec Canada

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Edward Dunnigan
(Address) Sandpoint Idaho R.F.D.

15. Filed Feb 27, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 23, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from
Did not Attend 19.. to ....., 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Information from Dr. O.E. Page who had previously treated and advised at time of death.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd A. Kemble, M. D.
Feb-25, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Feb. 25, 1930
20. Undertaker	Address
Moon Monterey	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

69387

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69387

PLACE OF DEATH
County of Elmore
City of Glenns Ferry

Registration District No. 33
Primary Registration District No. 2021

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Ellen Barkle

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James W Barkle

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Robert Edgeran
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Martha Molard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs John Candelbee
(Address) Glenns Ferry Ida

15. Filed 3-1, 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Feb 19, 1930
that I last saw her alive on 2-19, 1930
and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy Sic

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab-Sputum

(Signed) M. Friedeling M. D.
2-25, 1930 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry	2/20 1930

20. Undertaker G. C. Zueher Address Mountain Home Ida

RECEIVED MAR 3 1930

69388

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69388

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No.
Primary Registration District No.
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME William Bush Simmons
(a) Residence. No. 1234 Hill Crest Pasadena Calif.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeanne Simmons
6. DATE OF BIRTH (month, day and year): Dec 16 1884
7. AGE: Years 45, Months 2, Days 7. If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS
10. NAME OF FATHER: Francis Simmons
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Rhode Island
12. MAIDEN NAME OF MOTHER: Harriet Bush
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No 7°

14. Informant: Mrs. William B Simmons
(Address) 1234 Hill Crest Pasadena Calif.

15. Filed ..., 19...
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to Feb 23, 1930
that I last saw him alive on Feb 23, 1930
and that death occurred, on the date stated above, at 1.00 P m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Endocarditis, chronic
(duration) few yrs. mos. ds.

18. Where was disease contracted if not at place of death? In Twin Falls
Did an operation precede death? No Date of
Was there an autopsy? None
What test confirmed diagnosis? Clinical & Laboratory findings
(Signed) N. F. Passer M. D.
Feb. 25, 1930 (Address) Twin Falls, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pasadena Calif. Date of Burial: 19
20. Undertaker: P. J. Grossman Twin Falls Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

69389

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69389

PLACE OF DEATH
County of Arimo
City of Bannock

Registration District No. 83
Primary Registration District No. 2160
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

90

2. FULL NAME Ora John Barber
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ella L. Gill

6. DATE OF BIRTH (month, day and year) Sept. 7. 1888

7. AGE Years 41 Months 5 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Davenport Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Joseph Stinger
(Address) Arimo Ida.

15. Filed Mar 8, 1930 Mary E. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 3. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930; to Mar 3, 1930
that I last saw him alive on ~~Feb~~ Mar 1, 1930
and that death occurred, on the date stated above, at 4:00 p.m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. J. Hartogsen, M. D.
Mar 4, 1930 (Address) Downey, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Arimo Idaho | Date of Burial Mar. 6 1930

20. Undertaker J. Gary Benson | Address Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69390

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 20
(No. 7 Miles East of Boise on U.P. Right of Way.
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 164

2. FULL NAME H. W. Herr.
(a) Residence. No. Colville, Washington. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years About 37 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS
10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Pearl Allen. Boise, Idaho.

15. Filed 2-19, 1930 W. H. Rhode R.S. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Found dead Feb. 12th 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19, to , 19~~
~~that I last saw h alive on , 19~~
~~and that death~~ occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
~~The~~ CAUSE OF DEATH* was as follows:
Found hanging by the neck under Railroad bridge. Had been dead several weeks when found.
(duration) yrs. mos. ds.
~~CONTRIBUTORY~~ (~~Secondary~~) Suicide
No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W. McBratney Coroner, ~~M.B.~~
2/17/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 2/19/30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69391

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
(No. 23rd and Dora Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

2. **FULL NAME** Mrs. Ethel Kathleen Taylor.

(a) Residence. No. 1307 Washington St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Percy G. Taylor

6. DATE OF BIRTH (month, day and year) September 15th 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	4	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ludlow Shropshire, England.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) Percy G. Taylor. Boise, Idaho.

15. Filed 2-14-30 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 12th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8 '30, 19..., to 2/12, 1930
that I last saw her alive on 2/11, 1930
and that death occurred, on the date stated above, at 6 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Erysipelas, & Cavernous Sinus thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. ? mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C. J. Coats, M. D.
2/12/30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/13/30 19

20. Undertaker: M. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69392

PLACE OF DEATH

County of Ada.
City of Boise

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
(No. 3 Miles N.W. of Eagle.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

B

49

2. FULL NAME Herbert Francis Messecar
(a) Residence. No. 3 Miles N.W. of Eagle. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 39 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Messecar.

6. DATE OF BIRTH (month, day and year): April 16th 1863

7. AGE: Years 66, Months 9, Days 26. If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Waterford, Canada.

PARENTS

10. NAME OF FATHER: John Messecar.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.
12. MAIDEN NAME OF MOTHER: Caroline Hill.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Canada.

14. Informant (Address): Mrs. H. F. Messecar. Eagle, Idaho.

15. Filed 2-13, 1930 W. H. Rhodes R.S. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 12th (Day) 1930, 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 8th, 1930, to Feb 12th, 1930
that I last saw him alive on Jan. 30th 1930
and that death occurred, on the date stated above, at 8:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma Diffused of mesentery complication: ascites
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John Boick M. D.
2/14/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/14/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69393

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 16
(No. ... (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Ann Monteith
(a) Residence. No. 5 Miles S. W of Boise St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 26-1846

7. AGE Years 83 Months 6 Days 15 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Joseph Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Sarah Coy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant O. A. Monteith
(Address) R4 Boise Idaho

15. Filed 2-12, 1930 W. H. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 11th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1923, to Feb. 11, 1930, that I last saw her alive on Feb. 11, 1930, and that death occurred, on the date stated above, at 2:25 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia (lobar-double-posterior lower).

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) cardio-vascular (myocarditis-arteriosclerosis-chronic nephritis) (duration) 7 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Boise, Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical examination
(Signed) Dr. J. M. Downs, M. D.
Feb. 11, 1930. (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lincoln Nebraska
Date of Burial Feb 19 1930

20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69394

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 15
(No. State Penitentiary Dormitory.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Clarence M. Nicholson.

(a) Residence. No. 1401 N. 10th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 56 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Nicholson.

6. DATE OF BIRTH (month, day and year): February 9th 1868

7. AGE: 62 Years | Months: 0 | Days: 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Guard at Penitentiary.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Missouri.

PARENTS

10. NAME OF FATHER: James A. Nicholson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: Marilda Caldwell.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Don't Know.

14. Informant (Address): Arthur B. Golden, Boise, Idaho.

15. Filed 2-11, 1930 W. H. Rhodes, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 9th 1930 (Month) (Day) 19.. (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19.., to ....., 19.. ~~that I last saw a.. alive on~~ ....., 19.. ~~and that~~ death occurred, on the date stated above, at about 9 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead in Bath Room.
Acute Heart Trouble and
probably Cerebral Hemorrhage.
Natural Cause
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): No Inquest Held
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —
(Signed) W. McBratney, Coroner, ~~M. D.~~
2/10/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 2/12/30 19..

20. Undertaker: Wm. McBratney. | Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 8

DO NOT WRITE IN THIS SPACE
State File No. 69395

PLACE OF DEATH
County of Ada
City of

Registration District No.
Primary Registration District No. 2004
(No.)
Local Registrar's No. 314

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME John Cyrus Kent

(a) Residence. No. 5 Miles W of Boise Valley road
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Mary Kent

6. DATE OF BIRTH (month, day and year) April 25-1846

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10. NAME OF FATHER Miles Kent
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs. E. M. Fish
(Address) Boise Idaho R.D. # 6

15. Filed 2-4, 1930 W. N. Rhodes Registrar
R. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 27, 1930, to Feb 3, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:
Haemorrhage Cerebral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Geo Cadwell M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 4 1930
20. Undertaker	Address
Summers & Krebs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69396

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 63

(No. St Alphonsus)

(If death occurred in a hospital or institution, give its name instead of street and number.)

43

2. FULL NAME George H Miller

(a) Residence. No. Emmett Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): about 1869

7. AGE: About Years 61 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Andrew Little

9. BIRTHPLACE (city or town) (State or country): Oklahoma

PARENTS

10. NAME OF FATHER: No Record

11. BIRTHPLACE OF FATHER (city or town) (State or Country): No Record

12. MAIDEN NAME OF MOTHER: No Record

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No Record

14. Informant: Andrew Little

(Address): Emmett Ida

15. Filed 2-28, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/24, 1930, to 2/26, 1930

that I last saw him alive on 2/26, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

General Sepsis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma Involving Throat & Glands

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A Pringer, M. D.

2/, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Johns Cemetery

Date of Burial: 2/28 1930

20. Undertaker: Schreiber & McCann

Address: Boise

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69397

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 62
(No. Salvation Army Rescue Maternity Home.
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. **FULL NAME** Baby Jolley.
(a) Residence. No. Boise, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) February 2nd 1930

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER Marie Anna Jolley.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bingham Co. Idaho.

14. Informant (Address) Pearl Allen. Boise, Idaho.

15. Filed 2-24, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 21st 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/2, 1930, to 2/21, 1930
that I last saw him alive on 2-21, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Ammition

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Bm
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual
(Signed) [signature], M. D.
2/22/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: County Cemetery
Date of Burial: 2-24-30

20. Undertaker: Wm. McBratney.
Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69398

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 61
(No. 620 South 16th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

8 49

2. FULL NAME David P. Hayes.
(a) Residence. No. 620 South 16th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hayes.

6. DATE OF BIRTH (month, day and year) January 6th 1853

7. AGE Years 77 Months 1 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mercer Co. Mo.

PARENTS
10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Mrs. Mary E. Hayes. Boise, Idaho.

15. Filed 2-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 20th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19--, to ----------, 19--
~~that I last saw him~~ alive on ----------, 19--
~~and that~~ death occurred, on the date stated above, at 9 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Ear and side of Head.
No Medical Doctor in attendance for several months.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Wm. McBratney Coroner ~~M. D.~~
2/21/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 2/23/30 19
20. Undertaker Wm. McBratney. Address Boise, Idaho

Rx. Jones -

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69399

B

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 60

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

71a

2. **FULL NAME** Mrs. Alice Hoover.

(a) Residence. No. Boise, Idaho. R.#4. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Hoover.

6. DATE OF BIRTH (month, day and year) March 8th 1891

7. AGE: 38 Years | Months: 11 | Days: 4 | If LESS than 1 day, ---------- hrs. or ---------- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fresno, Calif.

PARENTS

10. NAME OF FATHER: ------Silvers.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address): Harry Hoover. Boise, Idaho. R#4.

15. Filed 2-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 20th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 20, 1930 that I last saw her alive on Feb 20, 1930 and that death occurred, on the date stated above, at 7:50A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Purulent meningitis.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Mastoiditis left.

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-17

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Spinal

(Signed) Urban H. Merrill, M. D.

2/20/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Feb. 22 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69400

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 59
(No. St. Alphonsus Hospital B
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Patrick Hardiman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1843

7. AGE: 86 Years | Months: 6 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Jas W. Hardiman
(Address) 1311 No 14 St Boise

15. Filed 2-20, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 18, 1930
that I last saw him alive on Feb 18, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pneumonia lobar
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery
Date of Burial: 2/21 1930

20. Undertaker: Schreiber & McCann
Address: Boise, Ida

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69401

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 58

B 88a

2. FULL NAME Homer George Patterson
(a) Residence. No. 1912 N. 15 St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Patterson
6. DATE OF BIRTH (month, day and year) Oct-4-1862
7. AGE 67 Years Months 4 Days 14 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER James H Patterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs H G. Patterson
(Address) 1912 N 15 St Boise Idaho
15. Filed 2-20, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930 to only, 19..
that I last saw him alive on Feb 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart - Endocarditis of Heart
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Bronchitis
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? at his home
Did an operation precede death? no Date of ~
Was there an autopsy? no -
What test confirmed diagnosis? none
(Signed) J W Cannon, M. D.
Feb 20, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Feb 22, 1930
20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69402

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 56

B 71A

2. FULL NAME William Hubert Walters
(a) Residence. No. Ustick Station St.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mar 8 - 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Seneca Kan.

PARENTS

10. NAME OF FATHER Ollie Walters
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cornie Kan.
12. MAIDEN NAME OF MOTHER Lela Badesheim
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Seneca Kan

14. Informant Ollie Walters
(Address) Boise Ida

15. Filed 2-20-1930 W. R. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 17, 1930, to February 18, 1930
that I last saw him alive on February 18, 1930
and that death occurred, on the date stated above, at 12:30 A m.
The CAUSE OF DEATH* was as follows:
Staphylococcic Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of
Was there an autopsy? no
What test confirmed diagnosis? Skin & Puncture
(Signed) Harold W. Lone, M. D.
2/18, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	2/21 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69403

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

2. FULL NAME Luis Strejcovsky
(a) Residence. No. 3 miles north Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? 27 yrs. mos. ds.

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Strejcovsky

6. DATE OF BIRTH (month, day and year): Oct. 22nd 1875

7. AGE: Years 54, Months 3, Days 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): self
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Czecho-Slovakia

PARENTS
10. NAME OF FATHER: Vaclav Strejcovsky
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Czecho-Slovacia
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or County): [illegible]

14. Informant (Address): Mrs. Nary Strejcovsky Nampa Idaho

15. Filed 2-19, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 10, 1930, Feby 17, 1930
that I last saw him alive on Feby 17, 1930
and that death occurred, on the date stated above, at 10:20 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Bronchopneumonia
Post operative

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Carcinoma of left Submaxillary Gland
(duration) ..... yrs. 9 mos. ..... ds.

18. Where was disease contracted if not at place of death? Nampa, Idaho
Did an operation precede death? Yes Date of Feby 10 1930
Was there an autopsy? No
What test confirmed diagnosis? Laboratory Clinical Operation
(Signed) James L. Stewart M. D.
2/19, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Cedarlawn-Nampa
Date of Burial: 2-20 1930

20. Undertaker: Wm D Dalley
Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lumbangy

DO NOT WRITE IN THIS SPACE
State File No. 69404

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 54

2. FULL NAME Samuel Dewitt McLain
(a) Residence. No. 1111-6th South St. Nampa Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth McLain

6. DATE OF BIRTH (month, day and year) 2/3/69

7. AGE: 61 Years | Months: 1 | Days: 13 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Hdwe & Implements
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chariton Iowa

PARENTS

10. NAME OF FATHER: Clinton J McLain
11. BIRTHPLACE OF FATHER (city or town) (State or Country): La Fayette Ohio
12. MAIDEN NAME OF MOTHER: Eva McLain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Jonesboro Indiana

14. Informant: Mrs S. D. McLain
(Address) Nampa, Ida

15. Filed 2-19, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw him alive on Feb 13, 1930
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Toxemia - Duodenal Hepatitis (Chronic
(duration) ... yrs. 3 mos. ... ds.
CONTRIBUTORY (Secondary) Abdominal adhesions
(duration) 10 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes. Date of 2/8-30
Was there an autopsy? No
What test confirmed diagnosis? X Ray — Clinical Exploration
(Signed) Ralph Falk M.D.
2/16, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Ida | Date of Burial: 2-16 1930

20. Undertaker: Fred K. Robinson | Address: Nampa Ida

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69405

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 004
Local Registrar's No. 53
(No. 7th and Front Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

P 524

2. FULL NAME Chuck Foo.

(a) Residence. No. 7th and Front St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	Chinese.	----------

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 83			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardener.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed 2-19 30 Clk Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---------- to ---------- 19..
~~that I last saw him alive on~~ ---------- 19..
~~and that death~~ occurred, on the date stated above, at ---------- m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

~~The~~ CAUSE OF DEATH* was as follows:
Found Dead in his room. Natural Cause.
Old Age - Senility -
(~~duration~~) yrs. mos. ds.
~~CONTRIBUTORY~~ (Secondary) No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Wm McBratney Coroner, M. D.
2/17/30, 19.. (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Chinese Cemetery.	2/18/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69406

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 52
(No. 527 Warren Street, South Boise)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B

164

2. FULL NAME Mrs. Margaret F. Green.
(a) Residence. No. Warren and Division St. South Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Green.

6. DATE OF BIRTH (month, day and year): November 7th 1844

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Westerly, R. I.

PARENTS

10. NAME OF FATHER: Luke Curly.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Margaret Failing.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): England.

14. Informant (Address): Henrietta E. Green. Boise, Idaho.

15. Filed 2-19, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 18th (Day) 1930, 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~, to ~~, 19~~ ~~that I last saw h~~ ~~alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at 4 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Old Age.
Natural Cause. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W McBratney Coroner, M.D.
2/18/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Weiser, Idaho. Date of Burial: 2-20-30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69407

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 51

(No. 1402 W. Idaho St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosanna Strathman

(a) Residence. No. 1402 W. Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20 1838

7. AGE: Years 91 | Months 7 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10. NAME OF FATHER: Joseph Terflinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Elizabeth Detwiler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: Mrs I R. Smith
(Address) 1402 W. Idaho St Boise Idaho

15. Filed 2-18, 1930 C. W. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 16 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to Feb 16, 1930
that I last saw her alive on Feb. 16, 1930
and that death occurred, on the date stated above, at 2.30 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. M. Robinson, M. D.
Feb 17, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 18 1930
20. Undertaker	Address
Summers & Krebs	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

Stewart

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69409

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. B 49

46

2. FULL NAME Nancy Maria - Campbell Dilley
(a) Residence. No. 1 Parma R#1 St. Parma Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edgar Dilley

6. DATE OF BIRTH (month, day and year): June-14-1874

7. AGE: Years 55, Months 7, Days 26. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Illinoise

PARENTS

10. NAME OF FATHER: Donald T. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinoise
12. MAIDEN NAME OF MOTHER: Pearlie J. Oliver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisc.

14. Informant: Mrs. F. M. Brown
(Address) 1406 Everett - Caldwell

15. Filed 2-17, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb- (Month) 12- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Feby 12, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 4:15 a.m.
The CAUSE OF DEATH* was as follows:
Ovarian Carcinoma - General abdominal metastasis
..... (duration) 1 yrs. 4 mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Parma Ida
Did an operation precede death? Yes Date of Oct 5 1929
Was there an autopsy? No
What test confirmed diagnosis? Inspection Hand
(Signed) James Stewart, M. D.
Feby 15, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roswell — Date of Burial: Feb-16 1930

20. Undertaker: S. V. Peckham — Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

Pettengill

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6941 1

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1001

Local Registrar's No. 47

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Verdie Maw

(a) Residence. No. ..... St. Meridian Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23-1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	4	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa Scott County

PARENTS

10. NAME OF FATHER Caleb Dunn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Ellen Cress

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Cash Maw

(Address) Eagle Idaho

15. Filed 2-15, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Feb~~ Feb 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/20, 1929, to 2/14, 1930
that I last saw ~~her~~ alive on 2/14, 1930
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardio-Vascular. Arteriosclerosis & Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Fred A Pettengill, M. D.

2/15, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb. 18 1930
20. Undertaker	Address
Summers & Trego	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69412

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 46

B #1

PLACE OF DEATH

County of Ada
City of Boise
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes Davidson Cooley

(a) Residence. No. 106 E. Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chester Campbell Cooley

6. DATE OF BIRTH (month, day and year) Sept. 19, 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chattanooga Tenn

PARENTS

10. NAME OF FATHER Robert Davidson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York City N. Y.
12. MAIDEN NAME OF MOTHER Eliza Mary Reynolds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oil City Pa.

14. Informant Mary Davidson
(Address) 1110 N. 8th Ave

15. Filed 2-15, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 13, 1930
that I last saw her alive on Feb 13th, 1930
and that death occurred, on the date stated above, at 9.15 p m.
The CAUSE OF DEATH* was as follows:
Septicaemia probably from throat infection
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Blood culture
(Signed) J. D. Springer, M. D.
2/14, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	2/15 1930
20. Undertaker	Address
Schneider & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6943

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 224
Local Registrar's No. 45
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Brough

(a) Residence. No. 1207 Hays St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Brough

6. DATE OF BIRTH (month, day and year) August 27th 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or ---min.---
76	5	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stone Cutter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER Thomas Brough.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant E. W. Brough.
(Address) Jerome, Idaho.

15. Filed 2-15, 1930 W. W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 27, 1930, to Feb 13, 1930
that I last saw him alive on Feb 13, 1930
and that death occurred, on the date stated above, at 11:45 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho - pneumonia
(duration) yrs. mos. 17 ds.
CONTRIBUTORY (Secondary) Heart dilatation 10 min
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
2/13/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	2/15/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69414
13

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 44
(No. 1408 N. 19th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. **FULL NAME** Mrs. Nellie West

(a) Residence. No. 1408 N. 19th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 0 yrs. 1 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas E. West.

6. DATE OF BIRTH (month, day and year) February 11th 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines, Iowa.

PARENTS

10. NAME OF FATHER Ike Heskett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Rachel Zoines.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant Dessie West.
(Address) Wendall, Idaho.

15. Filed 2-14-30 W. W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 12th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ , 19 , to , 19
~~that I last saw him~~ alive on , 19
~~and that~~ death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead in Bed. Had been in poor health for several years. Paralysis. Cerebral Hemorrhage.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No. Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Coroner
(Signed) W. McBratney M. D.
2/13/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Wendall, Idaho. Date of Burial Shipped 2-14-30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 2415

Local Registrar's No. 43

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marion I. Cimes

(a) Residence. No. 1415 N. 15 St. (Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-15-1845

7. AGE: Years 84 | Months 5 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York

PARENTS

10. NAME OF FATHER: Charles Nichols

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Adaline Finney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York,

14. Informant: Col. E. Masters

(Address) 1415 N. 15th Street Boise Idaho

15. Filed 2-13-30 C. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 12 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1927, 19..., to February 7, 1930 that I last saw her alive on February, 19... and that death occurred, on the date stated above, at 5-30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harold W. Love, M. D.

Feb. 18, 1930 (Address) 312 Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Idaho — Date of Burial: Feb-14 1930

20. Undertaker: Summers & Krebs — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69416

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. B 42

2. FULL NAME Anna Packenham Myers

(a) Residence. No. 1803 N. 24 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of James. I. Myers

6. DATE OF BIRTH (month, day and year) Dec 21-1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER David Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Rachel Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant James. I. Myers
(Address) 1803 N. 24 st Boise Idaho

15. Filed 2-11, 1930 C. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1929, to death, 19
that I last saw h er alive on Feb 10, 1930
and that death occurred, on the date stated above, at 9 45 P. m.,
The CAUSE OF DEATH* was as follows:
Cerebral thrombosis

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Early symptoms at Roberton Idaho.
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? Physical findings + autopsy
(Signed) Lyman F. West, M. D.
Feb 11, 1930 (Address) 413 E Eastman Bldg Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 12 1930
20. Undertaker	Address
Summers & Kirk	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stuart

DO NOT WRITE IN THIS SPACE
State File No. 69417

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 741

48

2. FULL NAME Albert G. Husted

(a) Residence. No. ..... St. Huntington Oregon
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche D. Husted

6. DATE OF BIRTH (month, day and year) Jan. 3-1883

7. AGE 47 Years | Months 1 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Wellington V Husted
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Mary R. Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Mrs A G Husted
(Address) Huntington Oregon Box 52

15. Filed 2-10, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1930, to Death, 19..., that I last saw him alive on Feb 8, 1930 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Thyreotoxicosis

..... (duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? Yes Date of Feb 8, 1930
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Lyman F West, M. D.
Feb 9, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Huntington Oregon | Date of Burial Feb 11 1930

20. Undertaker Summers & Krebs | Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69418

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. B 39

31

2. FULL NAME ~~Mary Heck~~ Maria Pichler
(a) Residence. No. 814 Mr. Kinley Ave ~~St.~~ (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): October 3-1911

7. AGE: Years 18, Months 4, Days 3. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ~~Germany~~ Austria

PARENTS
10. NAME OF FATHER: Joseph Pichler ~~adopted by Jack Heck~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Germany~~ Austria
12. MAIDEN NAME OF MOTHER: Katherina Schuler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ~~Germany~~ Austria

14. Informant: Mrs Katherina Heck
(Address) Boise, Ida

15. Filed 2-8, 1930 W. H. Rhodes, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-8, 1930, to 2-6, 1930
that I last saw her alive on 2-6, 1930
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis
(duration) 4 yrs. — mos. — ds.
CONTRIBUTORY (Secondary): Flu
(duration) yrs. 1 mos. — ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Sputum
(Signed) F. W. Almond, M. D.
2-7, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 2/7 1930.
20. Undertaker: Schreiber & Mr. Cann — Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

AFFIDAVIT

STATE OF IDAHO)
(ss.
COUNTY OF ADA)

KATHARINA HECK being first duly sworn, deposes and says that she resides in the City of Boise, Idaho, that her maiden name was Katharina Schuler, that she was formally married to Joseph Pichler, a native of Kaernthen, Austria, that she and her former husband are the parents of Maria Pichler who was born on October 3, 1911 and died on Feb. 6, 1930 in Boise, Idaho, that through error the name of the said Maria Pichler was entered in the Bureau of Vital Statistics of the State of Idaho in the Register of Deaths as Mary Heck, that she used to be known as Mary Heck, Jack Heck being the name of affiants later husband, but that the said Maria Pichler was never legally adopted by the said Jack Heck. That the said Maria Pichler was buried on February 7, 1930 in St. Johns Cemetery, Boise, Idaho.

Katharina Heck

Suscribed in my presents and sworn to before me this 1st day of December, 1932.

Gustav Kroger

Notary Public
Residing in Boise, Idaho

Boise Idaho
Dec-1-1932
mr Gustav Kroger is hereby authorized to correct the death certificate issued by me # to conform to the facts stated in the above affidavit. Signed
F. W. Almand M.D.

AFFIDAVIT

STATE OF IDAHO)
) ss.
COUNTY OF ADA)

KATHARINA HECK being first duly sworn, deposes and says that she resides in the City of Boise, Idaho, that her maiden name was Katharina Schuler, that she was formally married to Joseph Pichler, a native of Kaernthen, Austria, that she and her former husband are the parents of Maria Pichler who was born on October 3, 1911 and died on Feb. 6, 1930 in Boise, Idaho, that through error the name of the said Maria Pichler was entered in the Bureau of Vital Statistics of the State of Idaho in the Register of Deaths as Mary Heck, that she used to be known as Mary Heck, Jack Heck being the name of affients later husband, but that the said Maria Pichler was never legally adopted by the said Jack Heck. That the said Maria Pichler was buried on February 7, 1930 in St. Johns Cemetery, Boise, Idaho.

Katharina Heck

Suscribed in my presents and sworn to before me this 1st day of December, 1932.

Gustave Hoeger

Notary Public
Residing in Boise, Idaho

Boise, Idaho
Dec 1st 1932

Mr Gustave Hoeger is hereby authorized to correct the Death Certificate issued by us to conform to the facts stated in the above affidavit

Schreiber McCann

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69419

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. B 38
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Mrs. Anna L. Premo.
(a) Residence. No. 1113 Michigan Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Parley W. Premo.

6. DATE OF BIRTH (month, day and year): June 6th 1857

7. AGE: Years 72, Months 8, Days 0. If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Trumensburg, N. Y.

PARENTS

10. NAME OF FATHER: Solomon O. Rightmire.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Emma F. Hadley.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): N. Y.

14. Informant (Address): Mrs. A. L. Premo. Boise, Idaho.

15. Filed 2-7, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 6th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to 2/6, 1930
that I last saw her alive on 2/6, 1930
and that death occurred, on the date stated above, at 11 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Chronic nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) Alfred Body E Jr., M. D.
2/7/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 2/9/30, 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69420

Local Registrar's No. B 37

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

97

2. FULL NAME Althea Mc Millen

(a) Residence. No. 515 Logan St. Boise Ada Co Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER W Ga Dennis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Frances Pippen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Frank E. Mc Millen
(Address) 515 Logan St. Boise Idaho

15. Filed 2-7, 1930 U.A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1930, to Feb 5th, 1930, that I last saw her alive on Feb 5th, 1930, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:
Mesenteric Thrombosis
following removal of Uterus
Ovaries and Tubes
Pregnancy — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Ludbeck M. D.
Feb 7th, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Feb 8 1930
20. Undertaker	Address
Summers & Trefo	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69421

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. [illegible]
(No. 616 South 13th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

2. **FULL NAME** Mrs. Louise Neufeld.

(a) Residence. No. 616 South 13th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George Neufeld.

6. DATE OF BIRTH (month, day and year): October 24th 1904

7. AGE: 25 Years, 3 Months, 10 Days. If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Montreal, Canada.

PARENTS

10. NAME OF FATHER: Thomas Wristen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.
12. MAIDEN NAME OF MOTHER: Matilda Dunn
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Canada.

14. Informant (Address): George Neufeld. Boise, Idaho.

15. Filed 2-5, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 4th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 31, 1930, to February 4, 1930 that I last saw her alive on February 4, 1930 and that death occurred, on the date stated above, at 3:20 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs.
(acute miliary 6 mos.)

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): acute nephritis
(duration) — yrs. 0 mos. 3 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Findings
(Signed) [illegible], M. D.
2/5/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Dallas, Oregon. Date of Burial: Shipped 2-5-30 19

20. Undertaker: Wm. McBratney Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69422

PLACE OF DEATH

County of .....
City of .....
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. B 35
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Richards. Jr
(a) Residence. No. 901 E. Washington St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

1610

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Febr. 4 - 1930.

7. AGE	Years	Months	Days	If LESS than 1 day,
				3 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Harry W. Richards.
11. BIRTHPLACE OF FATHER (city or town) Denver
(State or Country)
12. MAIDEN NAME OF MOTHER Marguerite Ann Richards.
13. BIRTHPLACE OF MOTHER (city or town) Idaho City.
(State or Country)

14. Informant Harry W. Richards.
(Address) 901 East. Wash.

15. Filed 2-5, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 Feby 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 4, 1930, to Feby 4, 1930
that I last saw h[illegible] alive on Feby 4, 1930
and that death occurred, on the date stated above, at 4 30 a m.
The CAUSE OF DEATH* was as follows:

Prematurity
(Probably 6½ months foetus)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Alfred Bundy & Jr - M. D.
2/5, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	2/5 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69423

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B
Local Registrar's No. 34

140

2. **FULL NAME** Mike Lafranier.

(a) Residence. No. Cascade, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Don't Know.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 50				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS

10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Pearl Allen. Boise, Idaho.

15. Filed 2-1, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 28, 1930
that I last saw him alive on Jan 21, 1930
and that death occurred, on the date stated above, at 1:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hemiplegia Second.
Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Syphilis.
(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Lab

(Signed) Fred A Pettengill, M. D.
1/31/30, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery. Date of Burial: 2/1/30 19

20. Undertaker: Wm McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69424

PLACE OF DEATH

County of Boise

City of Smith Creek

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Charles Jacobson

(a) Residence. No. Smith Creek Boise Co. St. Smith Creek, Boise Co.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 1876

7. AGE Years 54 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Fred Konzen,
(Address) 511 South 18th St.

15. Filed 2-24, 1930 W. H. Rhodes R.S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Died Before Medical Aid Could Summoned No indication of Foul Play (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature] Professor Coroner

Feb 22, 1930 (Address) Idaho City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 2/25 1930.

20. Undertaker Schreiber & McCann — Address Boise, Ida.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69425

Local Registrar's No. 175

PLACE OF DEATH

County of Bannock
City of Bancroft Ida
Registration District No. 84
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 3 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bancroft Idaho

PARENTS

10 NAME OF FATHER Joe Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Lola Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah

14 Informant Joe Miller
(Address) Bancroft Idaho

15 Filed Mar 3 - 1930 Mrs. G. G. Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb - 3 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3 - 1930, to Feb - 3 - 1930,
that I last saw ~~him~~ alive on Feb 3 - 1930,
and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:
Impoverished Development due to unknown uterine nutrition

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) G G Fitz M. D.
Feb 4, 1930 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Bancroft Ida	Feb. 4 - 1930
20. Undertaker	Address
Had none.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69426

Local Registrar's No. 5775

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161.

(No. 441 S. Garfield)

(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Edward C. Kinney

(a) Residence. No. 441 S. Garfield St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND ~~of~~ (or) ~~WIFE~~ of Catherine Kinney

6. DATE OF BIRTH (month, day and year) July 11-1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	7	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Owen Kinney

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Collins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Catherine Kinney

(Address) Pocatello Idaho

15. Filed 3/3, 1930 J. H. Manning Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 1st 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 3-1, 1929, to 3-1, 1930, that I last saw h[illegible] alive on 2-26, 1930, and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows: General debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatic hypertrophy

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

3/3, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View	Mar 4 1930
20. Undertaker	Address
Schumacher Mendy	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 12 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. Lynn Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69427

Local Registrar's No. 5774

129

2. FULL NAME Levi C. Brinkerhoff

(a) Residence. No. Arco St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Otilla Neilson

6. DATE OF BIRTH (month, day and year) May 15 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	9	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheepman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Loa Utah

PARENTS

10. NAME OF FATHER Levi Brinkerhoff

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Eliza J. Cameron

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs Levi C. Brinkerhoff

(Address) Arco Idaho

15. Filed 3/26, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 25, 1930

that I last saw h alive on Feb 25, 1930

and that death occurred, on the date stated above, at 8 10a m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency & Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) [signature] M. D.

2/26/30 19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco Cemetery	Feb 27, 1930
20. Undertaker	**Address**
Arthur W. Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69428

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5772

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Ellen Varonia Hall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 14. 1906

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	3	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Richmond, Utah.

PARENTS

10. NAME OF FATHER Claus S Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grantsville Utah.
12. MAIDEN NAME OF MOTHER Getrude E. Libby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Main

14. Informant Claus S Anderson
(Address) Blackfoot R F D 2

15. Filed 3/3, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Feb 28, 1930
that I last saw her alive on Feb 28 1930
and that death occurred, on the date stated above, at 10 10 P m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Otitis media
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Brothers, M. D.
3-2, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas-Riverside Cem
Date of Burial: 3-3 1930

20. Undertaker: E J Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69429

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 577

2. FULL NAME Walter P. Garner Sr.

(a) Residence. No. 705 South Harrison St.
(Usual place of abode)
Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Esther Joseph

6. DATE OF BIRTH (month, day and year) November 2, 1856.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London, England.

PARENTS

10. NAME OF FATHER Henry Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Turner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. W. P. Garner
(Address) 705 South Harrison Ave. Poca.

15. Filed 3/24, 1930 J. K. Garner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 25. 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928 to Feb 25, 1930
that I last saw h... alive on Feb 25, 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Myocarditis -
Nephritis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. K. Garner M. D.
2/26/30., 19... (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. Date of Burial: 2/28/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatell

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69430

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2111
(No. St Anthony Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5770

88 B

2. FULL NAME Davie Dean Scott
(a) Residence. No. Aberdeen Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 28, 27

7. AGE: Years 3, Months 11, Days 25, If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pendleton Oregon

PARENTS
10. NAME OF FATHER: Ralph Scott
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Helesboro Texas
12. MAIDEN NAME OF MOTHER: Mina Tuttle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sprague Wash

14. Informant: Mina T. Scott
(Address) Aberdeen Idaho

15. Filed Feb 25, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1929, to Feb 25, 1930
that I last saw her alive on Feb 25, 1930
and that death occurred, on the date stated above, at 9 am m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis
(duration) yrs. 1½ mos. ds.
CONTRIBUTORY (Secondary) Mastoiditis, Tonsillitis
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? here
Did an operation precede death? yes Date of Feb 25-1930
Was there an autopsy? no
What test confirmed diagnosis? auscultation
(Signed) Pond Cwpond M. D.
Feb 25, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen Idaho
Date of Burial: Feb 26 1930

20. Undertaker: McHan Undt Co.
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69431

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 1124, N. Hayes St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5769

100a

2. FULL NAME Poralin J. Connell
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 21, 1854
7. AGE 75 Years | Months 8 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Oaklahoma

PARENTS
10. NAME OF FATHER J. Hargraves
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Cinthya Day
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant John Connell
(Address) Pocatello Ida.
15. Filed Feb 24 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 24 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb. 21, 1930
that I last saw her alive on Feb 21, 1930
and that death occurred, on the date stated above, at 9, a. m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
Feb 24 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello, Ida. | Date of Burial Feb 26 1930
20. Undertaker H. L. McHan | Address Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69432

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 1234 N. Main)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5768

157

2. FULL NAME Mary Cremin Lyons
(a) Residence. No. 1234 N. Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Con Lyons
6. DATE OF BIRTH (month, day and year) Expect Lot Unknown
7. AGE 64 Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Con Cremin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Johannah Lane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Con Lyons
(Address) Pocatello Idaho

15. Filed 2/24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 9 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Feb. 9, 1930
that I last saw her alive on Feb. 7, 1930
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:
Diabetic gangrene
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetes
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urinary findings
(Signed) [signature], M. D.
2/7, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lyons Mountain View Date of Burial Feb 11 1930
20. Undertaker Chumacher & Beasley Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69433

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony Hospital, Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5767

74a

2. FULL NAME John C. Williams
(a) Residence. No. Michaud, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Cora C. Keck

6. DATE OF BIRTH (month, day and year) Sept. 5, 1875.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Warehouse Manager
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Michaud, Warehouse

9. BIRTHPLACE (city or town) (State or country) Vermillion, South, Dakota.

PARENTS

10. NAME OF FATHER Richard F. Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Lona Paige
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. John C. Williams
(Address) Michaud, Idaho.

15. Filed 2/24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febuary 20, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Feb 20, 1930
that I last saw him alive on 2/20, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) [signature], M. D.
2/22/30., 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mount Moriah Cemetery Pocatello, Idaho. Date of Burial 2/23/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69435

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5764

(No. 247 North Ninth Ave. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Charles V. Shurtliff

(a) Residence. No. 247 North Ninth Ave. Poca. Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Nancy Alzina Smith

6. DATE OF BIRTH (month, day and year): January 26, 1930.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	0	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): ~~XXXXXXX~~ Ogden, Utah.

PARENTS

10. NAME OF FATHER: Leuman A. Shurtliff

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Alta Mira Gaylord

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Charles J. Shurtliff
(Address) 247 North Ninth Ave. Poca. Ida.

15. Filed 2/15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febuary 13, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Feb 18, 1930 that I last saw him alive on Feb 12, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pain, Palpable tumor

(Signed) A M Newton, M. D.

2/15/30., 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewisville, Idaho.

Date of Burial: 2/17/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69436

Local Registrar's No. 5763

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. St Marie Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Eva Clark Woodman

(a) Residence. No. St Marie Hotel St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of David H. Woodman

6. DATE OF BIRTH (month, day and year) January 15, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	--	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant David H. Woodman

(Address) Pocatello Idaho

15. Filed 2/13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 1930, to 2-13, 1930
that I last saw her alive on 2-12, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows: Carcinoma of Breast.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.
2/13, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	19
20. Undertaker	Address
Arthur W. Hall	Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69438

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 2
Primary Registration District No. 216
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5765

9 N

2. FULL NAME Edna Coe Pack

(a) Residence. No. Ranch North of Pocatello City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of M. N. Pack

6. DATE OF BIRTH (month, day and year) March 21, 1888.

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	10	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elco, Nevada.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant M. N. Pack
(Address) Pocatello, Idaho.

15. Filed 2/15/30., 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febuary 12, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/27/30, 19, to 2/12, 19 30
that I last saw h~~e~~ alive on 2/12, 19 30
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism.
Following Pneumonia - Lobar stormed
& Appendicectomy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of 2/2/30
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) H. Dawson, M. D.
2/15/30., 19 (Address) Poca. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wasatch Lawn Cemetery Salt Lake City, Utah.	2/17/30/19
20. Undertaker	Address
Arthur W. Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

69438

HAMNER C. IRWIN, M. D.
CARLSON BUILDING
SUITE 311-12-13-14
POCATELLO, IDAHO

This patient had & was making as smooth a convalescence as any I have ever had — Was out of bed day of 11 & 12th (wheelchair) and was to have gone home in 3 more days — Suddenly about 4:30 P.M. she complained of shortness of breath — cold — became cyanosed — pain epigastric region — weak rapid heart
Was conscious almost to end about 6 P.M. In my opinion she did not have any pathology in belly or lungs —
Pulmonary Embolus caused death.
H. C. Irwin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECE... MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69439

Registration District No. 55
Primary Registration District No. 2134
Local Registrar's No. 1

PLACE OF DEATH
County of Bear Lake
City of Fish Haven

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Zina Elvira Scofield

(a) Residence. No. Fish Haven Idaho St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a. If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of Ernest Nelson Scofield

6. DATE OF BIRTH (month, day and year) Mar 29 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	10	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Moriah Booth

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Emeline Alfred

13. BIRTHPLACE OF MOTHER (city or town) St. Charles Idaho
(State or Country)

14. Informant Carroll Scofield
(Address) Garden City Utah

15. Filed Feb. 17, 1930 Hannah J. Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from Jan 20, 1930, to Feb 16, 1930
that I last saw her alive on Feb 16, 1930
and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:
Cardio - Vascular - Renal Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) C O Nyman M. D.
2/17, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fish Haven Id.	2-18-1930
20. Undertaker	**Address**
C C. Shirley	Fish Haven

RECEIVED MAR 5 – 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69440

1 PLACE OF DEATH
County Bennock State Idaho Registered No.
Township or Village or
City De Smet No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josette Vincent

a8a

(a) Residence No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F
4 COLOR OR RACE Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Vincent

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 60 Months Days If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) General house
(c) Name of employer Keeping

9 BIRTHPLACE (city or town) Cowdalen
(State or country) Reservation Idaho

PARENTS
10 NAME OF FATHER Peter Hoskoso
11 BIRTHPLACE OF FATHER (city or town) Cowdalen
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) Kalispell
(State or country) Mont

14 Informant Joe Vincent
(Address) De Smet, Idaho

15 Filed Feb. 19, 1930 John Post
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Feb 17, 1930, that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:
Endocarditis acute

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
2/18, 1930 (Address) Dekon Wn

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Dr Smet Idaho
DATE OF BURIAL 2/19 1930

20 UNDERTAKER C. L. Schulerud
ADDRESS Tekoa, Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

FORM V. S. No. 5-12 M. 6-15-17

RECEIVED FEB 20 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 69441
Registered No.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Benewah
City of Sanders
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank H. Warren

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1892 (Year)

7. AGE: 37 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Henry A. Warren

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alice Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H.A. Warren
(Address) Sanders Idaho

15.
Filed Jan 29 1930 John Post Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 18 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1929 to Jan 18 1930
that I last saw h alive on Jan 12 1930
and that death occurred on the date stated above, at 10 30 P M.

The CAUSE OF DEATH* was as follows:
Pneumonary Tuberculosis
.....
.....
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Dr. C.B. Ellis M. D.
Jan 19 1930 (Address) Tekoa Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 6 mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? .....
Former or usual residence Sanders Idaho

19. PLACE OF BURIAL OR REMOVAL: Tekoa Wash
DATE OF BURIAL: Jan 21 1930

20. UNDERTAKER: C.L. Schulerud
ADDRESS: Tekoa Wn

RECEIVED FEB 20

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69442

1 PLACE OF DEATH
County Benewah State Idaho Registered No.
Township or Village Round Alen Reservation or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charley Smith

31

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Indian Word
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kalispel Mont

PARENTS
10 NAME OF FATHER: Kiatie Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kalispel Mont.
12 MAIDEN NAME OF MOTHER: Madaline
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kalispel Mont.

14 Informant: Neas Geary
(Address)

15 Filed Jan. 22, 1930 John Post REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1929, to Jan 21, 1930
that I last saw him alive on Dec 11, 1929,
and that death occurred, on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
1/21, 1930 (Address) Tekoa Wn.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: De Smet, Idaho
DATE OF BURIAL: Jan. 23 1930

20 UNDERTAKER: C. L. Schulerud
ADDRESS: Tekoa, Wash.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 4
V. S. No. 98

11—3184 GOVERNMENT PRINTING OFFICE

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 9443

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Esper Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

129

2. FULL NAME Christ Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	7	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mich

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country):

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs Harry Anderson
(Address): St Maries Ida

15. Filed March 4, 1930. Walter Boberg, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-27, 1929, to 2-28, 1930
that I last saw h[illegible] alive on 2-28, 1930
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
2-28-30, 19[illegible] (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Norway Mich	
20. Undertaker: Geo. Mitchell	Address: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69444

PLACE OF DEATH
County of Benewah
City of Emida

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

199

2. FULL NAME Per Gustas Helsing

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 67 Years: 1862 Months: July Days: 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: John Helsing
(Address) Emida

15. Filed March 1st, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19..., to —, 19...
that I last saw h— alive on —, 19...
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Murdered

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Fr skull strangulation Broken neck
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. Espe, Corner, M. D.
2/19, 1930 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emida Ida — Date of Burial: Feb 19 1930

20. Undertaker: Geo E Mitchell — Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6945

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

48B

2. FULL NAME Jeremiah McCarter

(a) Residence No. 330 - 4th Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eliza McCarter

6. DATE OF BIRTH (month, day and year) Dec. 18, 1874.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	1	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Street Commissioner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City of St. Maries

9. BIRTHPLACE (city or town) (State or country) Petrolia, Ontario

PARENTS

10. NAME OF FATHER Jeremiah McCarter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sarnia Ontario
12. MAIDEN NAME OF MOTHER Catherine Lince
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Godrich Ontario

14. Informant Mrs McCarter
(Address) St Maries Ida

15. Filed March 1st, 1930. Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1929, to Feb 12, 1930, that I last saw him alive on Feb 12, 1930, and that death occurred, on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical tests

(Signed) C A Robinson, M. D.
2/15, 1930 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Maries	Feb 15 1930
20. Undertaker	**Address**
Bro & Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69446

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. St Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

480

2. FULL NAME George A Terrian

(a) Residence. No. Malden Wash. St. Malden, Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	—		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Conductor. R R
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mil. R.R.

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Clifford Terrian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mathilda LeMar
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Henry W Terrian
(Address) Malden Wash.

15. Filed Feb 2nd, 19— Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Feb 1, 1930
that I last saw him alive on Jan 31, 1930
and that death occurred, on the date stated above, at 2 a.m.
The CAUSE OF DEATH* was as follows: Subacute bacterial
Endocarditis - mitral stenosis
Cerebral embolic - hemiplegia.
(duration) yrs. mos. 33 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E Cornwall, M. D.
2/1, 1930 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	Feb 2 1930

20. Undertaker	Address
Geo E Mitchell	St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69447

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 195

Local Registrar's No. 1

(No.) 746
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Marinda Smith

(a) Residence. No. Aberdeen, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 31, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2 days	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Aberdeen, Ida
(State or country)

PARENTS

10. NAME OF FATHER Charles Smith
11. BIRTHPLACE OF FATHER (city or town) Buffalo Mo.
(State or Country)
12. MAIDEN NAME OF MOTHER Marinda Smith
13. BIRTHPLACE OF MOTHER (city or town) Fishers Utah
(State or Country)

14. Informant Charles Smith
(Address) Aberdeen, Ida.

15. Filed 2/3, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to Feb. 2, 1930
that I last saw h[illegible] alive on Feb. 1, 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) , M. D.
2/3, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen, Ida	2-3 1930
20. Undertaker Friends	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69448

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

7

2. FULL NAME Marion Pauline Clinger
(a) Residence. No. Aberdeen, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 30 1928

7. AGE: Years 2, Months 0, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS

10. NAME OF FATHER Leland D Clinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ephraim Utah
12. MAIDEN NAME OF MOTHER Mildred Pearl Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mahaffy, Penn

14. Informant Leland D. Clinger
(Address) Aberdeen, Ida

15. Filed Feb 28, 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 28 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1930, to Feb. 28, 1930
that I last saw her alive on Feb. 28, 1930
and that death occurred, on the date stated above, at 5:15 A.m.
The CAUSE OF DEATH* was as follows:
Measles
~~Pneumonia~~
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) ~~Measles~~ Staphylococcic Infection of Tonsils - Throat: Bronchi & Lungs
..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Laboratory reports (3)
(Signed) M. C. McKinnon, M. D.
2-28, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen, Ida
Date of Burial: March/2 1930

20. Undertaker: Friends
Address: Aberdeen

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69449

Local Registrar's No. 21

14

PLACE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
(No. IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME B. F. Hines

(a) Residence. No. 512-18 Ave, S. Nampa, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. B. F. Hines

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	0	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nurseryman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant J. C. Gray
(Address) Blackfoot Idaho

15. Filed Feb 5, 1930 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1929, to February 2 1930
that I last saw him alive on February 1, 1930
and that death occurred, on the date stated above, at 5:15 a.m.
The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? No.
(Signed) Geo. Williams, M. D.
Feb. 2, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Nampa Idaho	
20. Undertaker E J Peck	Address Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Current

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Complete January 1930

RECEIVED MAR 5 - 1930

DO NOT WRITE IN THIS SPACE

State File No. 69450

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation, Idaho.

Registration District No. 121

City of

Primary Registration District No. 2194

Local Registrar's No. 2

(No. -----)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cahmeets Douglas.

(a) Residence. No. ------- St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Bannock Ind. 4/4	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Tazeno.

6. DATE OF BIRTH (month, day and year) ---- 1859-----

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	--	---	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Minnie Littlejohn

(Address) Blackfoot, Idaho U

15. Filed Feb. 26, 1930 W. Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 31, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930, to Jan. 31, 1930, 19

that I last saw him alive on Jan. 29, 1930, 19

and that death occurred, on the date stated above, at 4:P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

I

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY ----- (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Henry H. Wheeler, M. D.

....., 19.... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery, ft. Hall Reservation,	2-3-30 19

20. Undertaker Brown & Eldredge, Address Blackfoot, Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current

Complete January 1930

RECEIVED MAR 5 – 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 9451

County of Ft. Hall Reservation
City of Idaho.

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 19

(No. -----)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Esther Ingup

(a) Residence. No. ------ St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Don Ingup

6. DATE OF BIRTH (month, day and year): - 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	21	--	--	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft Hall Reservation

PARENTS

10. NAME OF FATHER: Fred Fisher

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Ruth Burt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Don Ingup
(Address): Ft. Hall, Idaho.

15. Filed Feb. 26, 1930 Mrs Walter E. Peters
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1926, to Jan 26, 1930, that I last saw her alive on Jan. 25, 1930, and that death occurred, on the date stated above, at 5%:A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs.

(duration) 3 yrs. 8 mos. 16 ds.

CONTRIBUTORY (Secondary) Epilepsy, Grand Mal.

(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Henry H. Wheeler, M. D.

, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Mission Ft. Hall Reservation, I-	29-1930 19

20. Undertaker: Brown & Eldredge, Address: Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 5 - 1930

Current

Complete January 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69452

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation, Idaho
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 18
(No. Village of Ft. Hall, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11a

2. FULL NAME Mary Ovary

(a) Residence. No. ------ St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Batise Ovary

6. DATE OF BIRTH (month, day and year) -1848---

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	0	)	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) ----
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Caroline Madzuweyu.
(Address) Ft. Hall, Idaho

15. Filed Feb. 26, 1930 Mrs Walter C. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1930 to Jan. 21, 1930
that I last saw her alive on Jan. 21, 1930
and that death occurred, on the date stated above, at 4:30 A m.
The CAUSE OF DEATH* was as follows:

Flu.

(duration) 11 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia-bronchial
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) Tommy R. Mueller, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Putnam Cemetery Ft. Hall Reservation, I-	23- 30 19

20. Undertaker Brown & Eldredge, Address Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current

Complete January 1930

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69453

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation, Idaho.
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 17
(No. 100a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leslie Edmo.

(a) Residence. No. ------- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 5/8	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Oct. 16, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	2	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ft. Hall Reservation
(State or country)

PARENTS

10. NAME OF FATHER Willie Edmo
11. BIRTHPLACE OF FATHER (city or town) Ft. Hall Reservation
(State or Country)
12. MAIDEN NAME OF MOTHER ~~Minnie~~ Elsie Mink
13. BIRTHPLACE OF MOTHER (city or town) Ft. Hall Reservation
(State or Country)

14. Informant Stella Edmo.
(Address) Ft. Hall, Idaho.

15. Filed Feb. 26, 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 10, 1930 (Month, Day, Year)
Treated by Dr. Ray, Pocatello

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at Noon m.
The CAUSE OF DEATH* was as follows:

Pneumonia, - bronchial.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) ----
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) Henry A. Wheeler, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery, Ft. Hall Reservation, I-	12*-30 19

20. Undertaker Agency Carpenter, Ft. Hall, Ida
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69459

PLACE OF DEATH

County of Bingham

City of Basalt

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

80

2. FULL NAME Venice Jensen

(a) Residence. No. Basalt, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. all her life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE 8 Years 3 Months 7 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Babe

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) Basalt, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Rulon M. Jensen

11. BIRTHPLACE OF FATHER (city or town) Kane County
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Allen

13. BIRTHPLACE OF MOTHER (city or town) St Anthony
(State or Country) Idaho

14. Informant Rulon Jensen
(Address) Basalt, Idaho

15. Filed Feb. 27, 1930 Mrs Helen E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 4, 1930, to Feb. 24, 1930

that I last saw her alive on February 24, 1930

and that death occurred, on the date stated above, at 2:: a m.

The CAUSE OF DEATH* was as follows:

Acute Endo-Carditis

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Rheumatism following measles (duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin Cutler M. D.

....., 19..... (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Basalt Cemetary

Date of Burial Feb 26 1930

20. Undertaker

Address

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69460

PLACE OF DEATH

County of Bingham

City of Bladkfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 30

(No. Blackfoot Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Amelia Britton Wilson

(a) Residence. No. 160 N. E. Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 16. 1862

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	6	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John W. Britton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Anna O'Rorrick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Jno. Britton
(Address) Blackfoot. Ida.

15. Filed Feb. 26, 1930 Mrs Walter E. Pakie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to Feb. 24, 1930
that I last saw h[illegible] alive on Feb 24, 1930
and that death occurred, on the date stated above, at 5:35 p m.

The CAUSE OF DEATH* was as follows:

Paralytic ileus

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms + physical findings

(Signed) Jno. H. Eagen M. D.

Feb 26, 1930 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	Feb 27 30
20. Undertaker	**Address**
Modern Mortuary, Blackfoot.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 5 - 1930

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2195

(No. Idaho Insane Asylum)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 8946 1

Local Registrar's No. 29

20-B

2. FULL NAME Albert Taylor

(a) Residence. No. New Plymouth, Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Albert Taylor

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Not Known

(c) Name of employer Unknown

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER J. S. T aylor

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Fred Hayes

(Address) Blackfoot, Idaho

15. Filed Mr. 26 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8:00 P.M. Feb 23, 1930 to Feb. 24, 11:20 AM

that I last saw him alive on Feb. 24, 11:20 A.M.

and that death occurred, on the date stated above, at 12:15 m.

The CAUSE OF DEATH* was as follows:

Unknown chronic disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.

Feb. 24th, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Edmonds Idaho — Date of Burial: on arrival 19

20. Undertaker: E J Funk — Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69462

PLACE OF DEATH
County of Bingham
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 2191
Local Registrar's No. 28
(No. Blackfoot, Idaho R.F.D. #3)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucile Burningham (Burningham.) 41

(a) Residence. No. Blackfoot. R. F. D. 3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Feamale	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19, 1921.

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	8	15	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot

PARENTS

10. NAME OF FATHER James V. Burningham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Annie Muir
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Dorothy Burningham
(Address) Blackfoot Ida

15. Filed Feb. 25 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. ~~June~~, 24, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 24, 1930
that I last saw he alive on Feb 24, 1930
and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Septicemia (Strepto-coccus) forearm
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Beck, M. D.
2/25, 1930 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	2-27-30 19

20. Undertaker	Address
Modern Mortuary,	Blackfoot. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69463

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 27
(No. Fannie Addition No number
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME John Daniel Sutton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 17th 1914

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
15	2	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER Carl Sutton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boston Mass

14. Informant C. S. Sutton
(Address) Blackfoot Idaho

15. Filed Feb 24 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Feb 21, 1930
that I last saw him alive on Feb. 21, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Brights disease
..... (duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Chemical
(Signed) H. W. Mitchell, M. D.
Feb. 24, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery
Date of Burial: 19

20. Undertaker: E J Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69464

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 26

(No. France Hospital West Judiciary St.
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Henry Hinton Webber.

(a) Residence. No. Eccles Hotel, Blackfoot. St. Pocatello, Idaho 49
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie M. Webber

6. DATE OF BIRTH (month, day and year): Jan 13 - 1864

7. AGE: Years 66 | Months 1 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tarnely Salesman and

(b) General nature of industry, business, or establishment in which employed (or employer): Hotel Clerk

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Old Town Timber Ill.

PARENTS

10. NAME OF FATHER: A H Webber.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Louise Lindsey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Carrie M. Webber
(Address) 911 Tulare Ave Berkeley Calif

15. Filed Feb. 19, 1930 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1930, to Feb 18, 1930
that I last saw him alive on Feb. 18, 1930
and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate gland
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic cystitis
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Phys Signs

What test confirmed diagnosis?

(Signed) W. E. Patrick M. D.

Feb. 19, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Green City Cemetery | Date of Burial: 2-20 1930

20. Undertaker: E T Peck | Address: Blackfoot

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69465

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. ~~2194~~ 1007 Local Registrar's No. 25
(No. Becks Hospital, Eccles Bldg.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

109B

2. FULL NAME Stella M Rogers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 8 1877

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	6	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairfield, Iowa

PARENTS

10. NAME OF FATHER Joseph E Rogers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fairfield, Iowa
12. MAIDEN NAME OF MOTHER Belle M Walkup
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Mrs. F. W. Rottman
(Address) Wilcox Arizona

15. Filed Feb. 18, 1930 Mrs. Walter C. Tabris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~March~~ Jan 18, 1930, to Feb 17, 1930
that I last saw her alive on Feb 17, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Bulbar Paralysis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Retropharyngeal abscess + nephritis

(duration) yrs. one mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Jan 20, 1930
Was there an autopsy? No Opened abscess
What test confirmed diagnosis? Paralysis of swallowing muscles of
(Signed) W W Beck, M. D.
2/18, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wilcox, Arizona. Date of Burial 19

20. Undertaker E J Peck Address Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69466

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 2K

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME JOHN P MARTIN

(a) Residence. No. ..... St. SWAN LAKE IDAHO
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Daisy A. Martin

6. DATE OF BIRTH (month, day and year) May-13-1870

7. AGE Years 59 Months 8 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Beaver City, Utah

PARENTS
10. NAME OF FATHER Daniel S. Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.J.
12. MAIDEN NAME OF MOTHER Eliz Ann Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Calif.

14. Informant James V. Torey Att.
(Address) Blackfoot, Idaho

15. Filed Feb 10, 1930 Mrs Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 9th, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1927, 19 to Feb 9th, 1930, 19
that I last saw him alive on Feb 8th, 1930, 19
and that death occurred, on the date stated above, at 12:15 A m.
The CAUSE OF DEATH* was as follows:

Cancer of stomach
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams M. D.
Feb 9th, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Swan Lake Ida — Date of Burial 2-12-1930

20. Undertaker Modern Mortuary — Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69467

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

92

2. FULL NAME Shirley Wilcock
(a) Residence. No. Shelley, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: H. G. Wilcock

6. DATE OF BIRTH (month, day and year): July 21, 1913

7. AGE: Years 16, Months 6, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iona, Idaho

PARENTS
10. NAME OF FATHER: Lee Nichols
11. BIRTHPLACE OF FATHER (city or town) (State or Country): United States
12. MAIDEN NAME OF MOTHER: Lillian Crofts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iona, Idaho

14. Informant: H. G. Wilcock
(Address): Shelley, Idaho

15. Filed Feb 10, 1930 Mrs Walton E. Patrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1930, to Feb. 8, 1930
that I last saw her alive on Feb. 8, 1930
and that death occurred, on the date stated above, at 6-45 p.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary): Hepatic abcess
..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. G. Pratt, M. D.
Feb 11, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley, Idaho
Date of Burial: February 12 1930

20. Undertaker: Jack A. Wood
Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 9468

Local Registrar's No. 25

14a

PLACE OF DEATH

County of Bannock
City of Blackfoot
Registration District No. 121
Primary Registration District No. 1007
(No. 537 E. Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah E. Sill

(a) Residence. No. South Oak St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Sill

6. DATE OF BIRTH (month, day and year) Jan 18 1846

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	84		18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Devon Eng

PARENTS

10. NAME OF FATHER Daniel Landman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Adaline Collyns
(Address) 6004 Grove St. Oakland Calif

15. Filed Feb 5, 1930 Thelton E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 4. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 4, 1930
that I last saw h[illegible] alive on Feb 3, 1930
and that death occurred, on the date stated above, at 3:10 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) ____ yrs. ____ mos. 5 ds.
CONTRIBUTORY (Secondary) Old age + arteriosclerosis
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
2/5, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groundlet Cemetery	Feb 6 1930

20. Undertaker E J Funk — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69469

PLACE OF DEATH

County of Blaine
City of Hailey
Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 10
(No. Hailey Clinical Hospital 24)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Percy L. Eldridge Fox

(a) Residence. No. ( ) St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Margie Gilum Eldridge

6. DATE OF BIRTH (month, day and year): Jan 17- 1904

7. AGE: Years 26 | Months 1 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Telephone Manager
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Carey Idaho.

PARENTS

10. NAME OF FATHER: Forest Sr Eldridge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Coalville Utah
12. MAIDEN NAME OF MOTHER: Ruth Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Margie Eldridge
(Address): Carey Idaho

15. Filed 3-1, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/21, 1930 to 2/25, 1930
that I last saw h[illegible] alive on 2/25, 1930
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Cerebra Spinal Meningitis
5 days.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Carey, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [illegible] M. D.
2/25, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Carey Ida. — Date of Burial: 2/26 1930
20. Undertaker: Harris & Sons. — Address: Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69470

PLACE OF DEATH

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 9

(No. Hailey Clinical Hosp.

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby A. C. Box

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 24 - 30

7. AGE: Years | Months | Days | If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer): X

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hailey - Ida

PARENTS

10. NAME OF FATHER: A. C. Box

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Theora Jensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rockland Idaho

14. Informant: A. C. Box
(Address) Hailey - Idaho

15. Filed 3 - 1, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/24, 1930, to 2/25, 1930
that I last saw her alive on 2/25, 1930
and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:
8 mo Baby - Premature
atelectasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [signature], M. D.

2/25, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Ida | Date of Burial: Feb 26 1930

20. Undertaker: Harry & Amos | Address: Hailey

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69471

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 8

PLACE OF DEATH
County of Blaine
City of Hailey

(No. 204 Wright)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Gale

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. E. Amos
(Address) Hailey Idaho

15. Filed 3-1, 1930 Robert H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: Found dead - Chronic Alcoholism

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Robert H. Wright, M. D.
2-23, 1930 (Address) C. Coroner Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey	Feb 23 1930

20. Undertaker	Address
Hanna & Amos	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69473

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

89

2. FULL NAME Synne J. Grondahl

(a) Residence. No. ..... St. ..... wright
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Mar 16-1876

7. AGE

Years	Months	Days	If LESS than 1 day,
53	10	28	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10. NAME OF FATHER Rudser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway-
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Celia Grondahl
(Address) Hailey

15. Filed 2-1, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1930, to 2-14, 1930
that I last saw her alive on 2-14, 1930
and that death occurred, on the date stated above, at 3:30 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. ..... mos. 1 hr ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Robert H. Wright M. D.
2-14, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridan Idaho.
Date of Burial: Feb 19 1930

20. Undertaker: Harris & Amos
Address: Hailey Ida.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69474

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

(No. 405 S. Lavina Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

11B

2. FULL NAME Henry Selle

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27th. 1883

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	8	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Brace City Michigan

PARENTS

10. NAME OF FATHER: Charles Selle

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sophia Myers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: John Selle
(Address) Sandpoint, Idaho.

15. Filed Mar. 1, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February ~~26th.~~ 27th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to Feb 27, 1930 that I last saw him alive on Feb 26, 1930 and that death occurred, on the date stated above, at 11:22 a. m.

The CAUSE OF DEATH* was as follows:

Influenza complicated by -
1- Infected Gall bladder
2- Thrombosis R brachial
3- Meningitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. 1 mos. 16 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Stackhouse, M. D.

March 1, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery
Date of Burial: March 2 1930

20. Undertaker: Moon Mortuary
Address: Sandpoint, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69475

PLACE OF DEATH
County of Bonner
City of Sagle

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mrs. Harriet F. Pettet

(a) Residence. No. Sagle St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W.R.Pettet

6. DATE OF BIRTH (month, day and year): Mar 4 1859

7. AGE: Years 70 | Months 11 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Richard Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Elizabeth Treadway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: W.R.Pettet
(Address): Sagle Idaho

15. Filed Feb. 27, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 26 (Day) 1930 (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from Feb-23, 1930, to Feb-26, 1930
that I last saw her alive on Feb-23, 1930
and that death occurred, on the date stated above, at 3;30AM m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Wendle M. D.
Feb-27, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Westmond | Date of Burial: 2/28 1930

20. Undertaker: Tunnell | Address: Sandpoint Ida

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69476

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 19

PLACE OF DEATH
County of Bonner
City of Sandpoint
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME Roscoe Leslie Bower

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 16 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Ida.

PARENTS
10. NAME OF FATHER Leslie Bower
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan
12. MAIDEN NAME OF MOTHER May Pebsley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant John Sell
(Address) Sandpoint Idaho.

15. Filed Feb. 22 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:
Suicidal:
Carbon monoxide gas from automobile exhaust.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. B. Moon Coroner M. D.
Feb. 19, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Feb. 22, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69478

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Hugh Corley 90

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE: Years 63 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital
(Address) Sandpoint, Idaho.

15. Filed Feb. 22, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 18, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-14, 1930, to Feb-18, 1930
that I last saw him alive on Feb-13, 1930
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) Floyd E. Randle, M. D.
2-19-1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: Feb. 22, 1930

20. Undertaker: R. E. Wessa — Address: Priest River, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 99479

PLACE OF DEATH
County of Bonner
City of Ponderay
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 16
(No. 127)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruby Lois Pomrinke

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 25, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ponderay
(State or country) Idaho

PARENTS

10. NAME OF FATHER John Pomrinke
11. BIRTHPLACE OF FATHER (city or town) Webster
(State or Country) S. Dakota
12. MAIDEN NAME OF MOTHER Susie Neva
13. BIRTHPLACE OF MOTHER (city or town) Kensel
(State or Country) N. Dakota

14. Informant John Pomrinke
(Address) Ponderay, Idaho.

15. Filed Feb. 19, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 17th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7, 19__, to ____, 19____
that I last saw h__ alive on Feb 17, 19____
and that death occurred, on the date stated above, at 2 p m.
The CAUSE OF DEATH was as follows:
Acute Gastro-Intestinal Indigestion
1 hr — (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) Floyd E. Wenger M. D.
2-19, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Feb. 19 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69482

Local Registrar's No. 13

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Franz Haver Strodel

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fox Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L. D. Moon Coroner

(Address) Sandpoint, Idaho.

15. Filed Feb. 19, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH About February (Month) 15th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Unknown Chronic Heart Disease.

Hostory asthma and heart attacks about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. D. Moon Coroner, M. D.

Feb. 18, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Feb. 21 1930

20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69483

PLACE OF DEATH

County of Bonner

City of Sandpoint,

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 12

(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Myrvin Thompson Mc Elroy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen McElroy

6. DATE OF BIRTH (month, day and year): October

7. AGE: 71 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: William McElroy

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Isabelle Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: John McElroy.
(Address) S. Pasidena, Cal.

15. Filed Feb. 19, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 14, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 14, 1930, to February 14, 1930 that I last saw him alive on February 14th, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [signature], M. D.

2-19, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery | Date of Burial: Feb. 20 1930

20. Undertaker: Moon Mortuary | Address: Sandpoint, Ida

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69484

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2157
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME John D Taylor

(a) Residence. No. Sagle St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ETTA Taylor

6. DATE OF BIRTH (month, day and year) Feb 2 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	0	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Richard Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Elizabeth Breentray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) PA.

14. Informant Mrs Chas Murphy
(Address) Sagle Ida

15. Filed Feb 14, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Feby 11, 1930
that I last saw him alive on Feby 10, 1930
and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism, Chronic

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Wm F Taylor, M. D.
Feby 13, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Feb 14 1930

20. Undertaker	Address
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69485

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 10

(No. 115 Lake street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Phil Willi

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Willi

6. DATE OF BIRTH (month, day and year): Oct 12 1880

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
49	3	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Packer & Butcher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Frederick Willi

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Franciska Becker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs Ida Willi

(Address) 115 Lake St.

15. Filed Feb. 14, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at About 5:30 P m.

The CAUSE OF DEATH* was as follows: Automobile accident: Auto plunging from Bridge across Lake Hand'd breakin on to ice. Traumatism (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) R. H. Moon Coroner M.D.

Feb. 15, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery

Date of Burial: Feb 15 1930

20. Undertaker: Turnbull Co

Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69486

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 7

Primary Registration District No. 2155

Local Registrar's No. 9

(No. 112 Hickory Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirley Alice Beatty

(a) Residence. No. 112 Hickory Street St.

(Usual place of abode)

Length of residence in city or town where death occurred. 5 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 16, 1924

7. AGE: Years 5 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sandpoint Idaho.

PARENTS

10. NAME OF FATHER: Edward Beatty

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Edna Kirkhoven

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): South Dak.

14. Informant: Mrs. Edna Beatty

(Address): Sandpoint, Idaho.

15. Filed Feb. 9, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 6, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 6, 1930

that I last saw her alive on Feb 6, 1930

and that death occurred, on the date stated above, at 10:55 p. m.

The CAUSE OF DEATH* was as follows:

Influenza

Tracheo bronchitis dominant feature. Duty cyan.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? No improvement

Patient was given 5000 U. Anti Strep

(Signed) C. P. Stackhouse, M. D.

Feb. 9, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Feb. 9, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69487

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

50

2. FULL NAME Henry Narum

(a) Residence. No. ..... St. Kootenai, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Male

4. COLOR OR RACE White

5. ~~Single~~, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Narum.

6. DATE OF BIRTH (month, day and year) Dec 18, 1882

7. AGE — Years 47 — Months 1 — Days 13 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber mill.
(c) Name of employer Humbird Lbr. Co.

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Ole Narum

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs. Bertha Narum
(Address) Kootenai, Idaho.

15. Filed Feb. 3, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 27th 1930, to February 1st 1930
that I last saw him alive on January 31st 1930
and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:

Sarcoma of Right Inferior Maxilla

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no

(Signed) H. B. Graves, M. D.
2-1, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River Cemetery	Feb. 3, 1930
20. Undertaker	Address
R. E. Wessa	Priest River, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69488

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 88
Primary Registration District No. 237
(No. Hope Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

43

2. FULL NAME John Silas Timmerman

(a) Residence. No. Hope Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Delia Timmerman

6. DATE OF BIRTH (month, day and year) Aug II 1855

7. AGE Years	Months	Days	If LESS than 1 day,
74	7	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Henderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant H.S.Dowdy
(Address) Spokane Wash

15. Filed Feb 20, 1930 John Lawson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) I8 (Day) I930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov, 19 29, to Feb, 19 30
that I last saw him alive on Dec, 19 30
and that death occurred, on the date stated above, at 7;30 A m.
The CAUSE OF DEATH* was as follows:
CARCINOMA of Neck

(duration) 5- yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) Floyd A. Wendle M. D.
2-18, 19 30 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hope Idaho	2/20/30 19

20. Undertaker	Address
Turnbull Company	sandpoint

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69489

PLACE OF DEATH

County of Bonneville
City of ~~Priest River~~ Newport

CERTIFICATE OF DEATH

Registration District No. 85
Primary Registration District No. 2185
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 2

74a

2. FULL NAME William Hughes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 3 1886

7 AGE: Years 43 | Months 5 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woods worker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer: U.S. Forest Service

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Jule Le Blanc
(Address) Newport Washington

15 Filed Feb 20, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1928, to Feb. 20, 1930, that I last saw him alive on Feb. 17, 1930, and that death occurred, on the date stated above, at about 1:00 a. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Instantaneous
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Syphilis
Years
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Wasserman for syphilis
~~(Signed)~~ A. D. Schlottbauer, M. D.
Feb. 20, 1930 (Address) Newport, Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of ~~Burial~~, ~~Cremation~~, or Removal: Newport Washington
Date of Burial: Feb. 23 1930

20. Undertaker: Booth & Sherman
Address: Newport.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69490

PLACE OF DEATH

County of Boundary

City of Leonia

Registration District No. 79

Primary Registration District No. 515-6

Local Registrar's No.

(No.) 146

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Skands

(a) Residence. No. St. Libby Montana
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 - 1874

7. AGE Years 55 Months 3 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer North Idaho Metals & Mining Co

9. BIRTHPLACE (city or town) (State or country) Frandjem Norway

PARENTS

10. NAME OF FATHER Jens Grandey Skands

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Frandjem Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Frandjem Norway

14. Informant Solon Rawlo
(Address) Libby Montana

15. Filed Feb. 1, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Accidental death
Caught in blast in mine
Mutilation of Entire body
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ken Bowell Coroner, M. D.

2/1, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Libby, Mont

Date of Burial 19

20. Undertaker H. R. Crouch, Bonners Ferry

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69491

PLACE OF DEATH

County of Boundary

City of Leonia

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No. 186

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Herberg

(a) Residence. No. ..... St. Libby Montana
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE of~~ Cora Ester Herberg

6. DATE OF BIRTH (month, day and year) Feb 24, 1893

7. AGE Years 36 Months 11 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) North Idaho Metals & Mining Co

(c) Name of employer "

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Frank Herberg

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Solon Ramlo
(Address) Libby Montana

15. Filed Feb. 1, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Accidental Death
Caught in blast in mine
Mutilation of entire body
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Rue Bowell, M. D.

2/1, 1930 (Address) Bonners Ferry Ida Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Libby, Mont. Date of Burial 19

20. Undertaker H. R. Crouch, Bonners Ferry. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 17 1930

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69492

Local Registrar's No. .....

48B

2. FULL NAME Harry Saddler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 25-1854

7. AGE Years 75 Months 3 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Lumberman & general contractor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Liverpool England

PARENTS

10. NAME OF FATHER Saddler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Manchester England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant P. L. Saddler
(Address) Bonners Ferry, Ida

15. Filed Jan. 28, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1924, to Jan. 26, 1930
that I last saw him alive on Jan. 26, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no. Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) E. E. Fry, M. D.

1/28, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bonners Ferry Date of Burial Jan 29 1930

20. Undertaker H. R. Crouch Address Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69493

PLACE OF DEATH

County of Boundary Registration District No. 79
City Bonners Ferry Primary Registration District No. 2154
Local Registrar's No.

(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ottelia Polzin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 25 - 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	2		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Bart. Savendofski
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Louise Bey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Lawrence Polzin
(Address) Bonners Ferry, Ida.

15. Filed Jan. 26, 1930 D. E. Fry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2:10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration with angina pectoris.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical examination

(Signed) D. E. Fry, M. D.
Jan. 26, 1930. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Jan. 27 1930
20. Undertaker	Address
H. K. Crouch	Bonners Ferry

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69494

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry, Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME R. P. Wood
(a) Residence. No. St. Libby, Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 74 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Hospital Records
(Address) Bonners Ferry, Ida

15. Filed Jan. 23, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to Jan 22, 1930
that I last saw him alive on Jan 22, 1930
and that death occurred, on the date stated above, at 9:45 P m.
The CAUSE OF DEATH* was as follows:
Prostatic hypertrophy
Chronic Cystitis
~~Prostatic~~ Chronic Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prostatectomy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Libby Montana
Did an operation precede death? Yes Date of Jan 16-1930
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) R M Bowell, M. D.
Jan 23, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Libby, Mont
Date of Burial 19

20. Undertaker H. R. Crouch, Bonners Ferry
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69495

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Ray Ellis O'Brien
(a) Residence. No. ..... St. Moyie Springs
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 14-1929

7. AGE Years: 2 Months: 3 Days: 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry

PARENTS

10. NAME OF FATHER R. J. O'Brien
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Virginia
12. MAIDEN NAME OF MOTHER Viola Fuller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Calif.

14. Informant R. J. O'Brien
(Address) Moyie Springs

15. Filed Jan. 30, 1930. E. E. Frey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Malnutrition
Bronchopneumonia
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Convulsion
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) R. M. Bowell, M. D.
Jan 20, 1930 (Address) Coroner Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cemetery Montana, Near Leonia, Ida. Date of Burial: Jan 21 1930

20. Undertaker Address

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69496

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Julia Ella Peel

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE:
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter Peel

6. DATE OF BIRTH (month, day and year): Mar 5 1876

7. AGE: Years 53, Months 10, Days 14. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Northport Wash.

PARENTS

10. NAME OF FATHER: Richard A. Fry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Justine Ira
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Collville Wash.

14. Informant: Mrs. A. Bunting
(Address): Bonners Ferry

15. Filed Jan. 20, 1930 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 19th. (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept., 1929, to Jan. 19th 1930.
that I last saw her alive on Jan. 19th, 1930
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the pancreas.
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?
(Signed) E. E. Fry, M. D.
Jan. 20, 1930. (Address) Bonners Ferry, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. Date of Burial: Jan 21 1930

20. Undertaker: H. R. Crouch, Bonners Ferry. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69497

PLACE OF DEATH
County of Boundary. Registration District No. 79
City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No.
(No.) 101 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Lorenck
(a) Residence. No. St. Post Falls, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the wdrd): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Lorenck
6. DATE OF BIRTH (month, day and year): June 10-1860
7. AGE: Years 69 | Months 7 | Days 7 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Austria

PARENTS
10. NAME OF FATHER: Wenzel Lorenck
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Austria
12. MAIDEN NAME OF MOTHER: Barbara Lorenzenky
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria

14. Informant: Mrs. Anna Lorenck
(Address): Bonners Ferry, Ida.
15. Filed Jan. 18, 1930. E E Eng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 17 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12:15 A m.
The CAUSE OF DEATH* was as follows:
Pneumonia.
(History of myocardial symptoms and nephritis.)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. 6 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No. History.
What test confirmed diagnosis?
(Signed) E E Eng, M. D.
Jan. 18, 1930. (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Chewelah, Wash. Date of Burial 19
20. Undertaker: H. R. Cronk, Bonners Ferry Ida. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69513

PLACE OF DEATH
County of Butte
City of Soot River

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 18

(No.) 1618
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maryland Noble

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day and year) Feb. 28. 30

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				3

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) Soot River Idaho
(State or country)

PARENTS

10. NAME OF FATHER James Alexander Noble
11. BIRTHPLACE OF FATHER (city or town) Soot River
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Alice La Verda Reynolds
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Murray Utah

14. Informant Alex R. Noble
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to Feb 28, 1930
that I last saw her alive on Feb 28, 1930
and that death occurred, on the date stated above, at 7:30 P. m.
The CAUSE OF DEATH* was as follows:

Premature separation of Placenta preceding birth.

(duration) 0 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. H. Egbert, M. D.
Feb 28, 1930 (Address) Soot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAR 15 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 6951 4
Registered No. 17

1. PLACE OF DEATH
County of Butte
City of Arco
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Martel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 12 (Day) 1862 (Year)

7. AGE: 67 Yrs. ..... Mos. 1 ds. 23
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): W Portugales France

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fidele Sauzier
(Address) .....

15. Filed Feb. 5, 1930
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 23 1930, to Feb. 4 1930
that I last saw him alive on Feb 3 1930,
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Septicemia resulting from frozen hands.
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Myocarditis
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. R. Egbert M. D.
Feb. 5 1930 (Address) Arco Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: Feb 5 1930

20. UNDERTAKER: Theo R. Garner — ADDRESS: Arco Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC'D FEB 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10515

Registration District No. 58
Primary Registration District No. 2138
(No.)
Local Registrar's No. 19

PLACE OF DEATH
County of Blaine
City of Fairfield
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

146

2. FULL NAME Leona Peck

(a) Residence. No. Fairfield Ida. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): married

6a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Gaylord A. Peck

6 DATE OF BIRTH (month, day and year) Oct. 14-1902

7 AGE: 28 Years | Months: 4 | Days: 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Denver Colorado

PARENTS

10 NAME OF FATHER: Andrew J. Lazarus
11 BIRTHPLACE OF FATHER (city or town) (State or country): France
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Gaylord A. Peck
(Address): Fairfield. Ida.

15 Filed Feb. 25, 1930 Minnie Perkins
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 17. (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7., 1930, to Feb. 17., 1930
that I last saw h~~er~~ alive on Feb. 16., 1930
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows: Infection following Childbirth

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms

(Signed) A. A. Sheets, M. D.
....., 19..... (Address) Fairfield

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Mt. View Cemetery Fairfield Idaho
Date of Burial: Feb. 19 1930

20. Undertaker
Address

RECEIVED MAR 1 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69516

PLACE OF DEATH

County of Canyon
~~City~~ of Rural

Registration District No. 7
Primary Registration District No. 2006
(No. —)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME William J. Turner
(a) Residence. No. 1-mile S of Nampa ~~St.~~ (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mar 17-1854

7. AGE: 75 Years; Months: 11; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs Bertha Roy
(Address) Boise Idaho

15. Filed 3-5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1927, to Feb 6, 1930
that I last saw him alive on Feb 6, 1930
and that death occurred, on the date stated above, at 2 9 m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
arteriosclerosis & Interstitial nephritis
(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Hemoglobin
(Signed) H P Ross, M. D.
Feb 7, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem — Date of Burial: 2-8 1930

20. Undertaker: F. K. Robinson — Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69517

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

128

2. FULL NAME Mattie Harris

(a) Residence. No. 1224 - 13 ave S St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-15-1878

7. AGE: Years 52 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work As Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario, Canada

PARENTS
10. NAME OF FATHER Jas. Adrain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER McCallister
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs Addie Dorsey
(Address) Nampa Ida

15. Filed 3-5, 1930 Bertha Conway Registrar

5

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 -, 1929, to Feb 3, 1930
that I last saw her alive on Feb 2, 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis.
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Routine Lab.
(Signed) Samuel A Swayne M. D.
2-5-, 1930 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem | Date of Burial: 2-4 30

20. Undertaker: F. K. Robinson | Address: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69518

Registration District No. 7
Primary Registration District No. 7006
Local Registrar's No. 8

PLACE OF DEATH

County of Canyon
City of Nampa
(No. 3d st + 8th ave S)
(If death occurred in a hospital or institution, give its name instead of street and number.)

114

2. FULL NAME. Theodore Strickland

(a) Residence. No. 3d st + 8th ave S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3-1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs J. A. Strickland
(Address) Nampa Ida

15. Filed 3-5, 1930 Della Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 5, 1930
that I last saw him alive on Feb 5, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? physical signs
(Signed) G. A. Ross, M. D.
Feb 7, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kahlertown Cem	2-7, 1930
20. Undertaker	Address
F. K. Robinson	Nampa Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — REGISTERED MAR 10 1930

Registration District No. 7

Primary Registration District No. 2006

File No. 69519

County of Canyon

City of Nampa, RR 2 (No. ..... St.)

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Infant

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Nampa Ida.

10. NAME OF FATHER O. Roy Call

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Rosetta Mallary

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Call
(Address) Nampa Ida.

15. Filed 3-5 1930 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1930 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from Feby 5 1930, to Feb 5 1930, that I last saw her alive on Feb 5 1930, and that death occurred on the date stated above, at 8 20 P.M.

The CAUSE OF DEATH* was as follows:
Born prematurely at about 7½ month.
3 hours & 20 min.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Murray M. D.
3/6 1930 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ~
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	2-7 1930

20. UNDERTAKER	ADDRESS
F. E. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69520

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

2. FULL NAME Kenneth Christian Bonnerue

206

(a) Residence. No. Waddell apts St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): ✓

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6. DATE OF BIRTH (month, day and year): 2-13-30

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED: ✓

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nampa Ida

PARENTS

10. NAME OF FATHER: A. R. Bonnerue

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ashton, Ida

12. MAIDEN NAME OF MOTHER: Vera Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: R. R. Bonnerue
(Address): Waddell apts 9, Nampa

15. Filed 3-5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 15, 1930

that I last saw her alive on Feb 15, 1930

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Premature birth 7th mo (Debilitated)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V C Bellamy M. D.

Feb 17, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem. | Date of Burial: 2-17 1930

20. Undertaker: J. K. Robinson | Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69521

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

74a

2. FULL NAME Eliza Housenwarth

(a) Residence. No. 1005- 9th ave S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
*(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) Aug 8- 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Thos Benson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Ann Beachum
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs Geo. Lucas
(Address) Nampa Ida

15. Filed 3-5, 1930 Leetha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 8, 1930
that I last saw her alive on Feb 8, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Acute haemorrhagic pan

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace Wellman, M. D.
2/8, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	2-10 1930
20. Undertaker	Address
F. K. Robinson	Nampa Ida

B

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69522

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 22
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Irene E. Hoffman
(a) Residence. No. 107 - 17th Ave. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C. H. Hoffman

6. DATE OF BIRTH (month, day and year) Dec. 21st 1901

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	1	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Elba Idaho

PARENTS

10. NAME OF FATHER: Leavert Van Leuven
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Marker E. Barker
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Elba - Idaho

14. Informant (Address): C. H. Hoffman Nampa, Idaho

15. Filed 3-5, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 5th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 5, 1930
that I last saw her alive on Feb 5, 1930
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute pinotonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Affinement abscess
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 2-2-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) V C Bellmap M. D.
2-22, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Kohlerlaw - Nampa
Date of Burial: 2-9 1930

20. Undertaker: Mrs. Nina M. Oakley
Address: Nampa, Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69523

RECEIVED MAR 10 1930

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Off Holly Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

101B

2. FULL NAME Doris Mae Galloway
(a) Residence. No. Off Holly Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) October 24-1929

7. AGE: Years 1 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa, Idaho

PARENTS
10. NAME OF FATHER Loren Galloway
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Walla Walla, Wash
12. MAIDEN NAME OF MOTHER Mildred Shonkyler
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Salt Lake Utah

14. Informant (Address) Loren Galloway Nampa Idaho

15. Filed 3-5, 1930 Seitha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1st (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw her alive on Feb 18, 1930
and that death occurred, on the date stated above, at 5:45 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W C Holt, M. D.
3/1, 1930 (Address) Nampa

19. Place of Burial, Cremation, or Removal: Walla Walla Wash. Date of Burial: 19

20. Undertaker: W. D. Talley Address: Nampa, Ida

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69524

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006 Local Registrar's No. 24
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

17 506

2. **FULL NAME** Joseph Morgan Park
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) F B 19th 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER Clyde R. Park
11. BIRTHPLACE OF FATHER (city or town) Arkansas
(State or Country)
12. MAIDEN NAME OF MOTHER Eva N. Delaney
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or County)

14. Informant (Address) Mr. Clyde R. Park Nampa, Ida.

15. Filed 3-5, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 19th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., at birth Feb 19, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 2 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Still born
Serious sickness of mother
Caused premature birth
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? .....
What test confirmed diagnosis? Clinical
(Signed) O. C. Bellmuth, M. D.
2-21-, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	19
20. Undertaker	Address
Wm. D. Lallen	Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69526

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. R F D Caldwell Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

11B

2. FULL NAME Wm Norman Benton
(a) Residence. No. R F D (Riverside District) St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21 1929

7. AGE Years: - - - - Months: 3 Days: 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER Asa D.Benton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Rose Wood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Asa D.Benton
(Address) R F D Caldwell Idaho

15. Filed 3-5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 6 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 5, 1930
that I last saw him alive on Feb 5, 1930
and that death occurred, on the date stated above, at 5 30 P m.
The CAUSE OF DEATH* was as follows:
Flu. (Influenza)
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P Belknap, M. D.
2/8, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cemetery
Date of Burial: Feb 7-30 19

20. Undertaker: Paul L.Case
Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69527

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

74B

2. FULL NAME Edith Lauraine Marsh
(a) Residence. No. Parma St. —
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year)
7. AGE — Years — Months — Days 3 If LESS than 1 day, — hrs. or — min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Parma Idaho

PARENTS
10. NAME OF FATHER Frank Marsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pryscott Kansas
12. MAIDEN NAME OF MOTHER Lila Smalley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Williams Iowa

14. Informant Frank Marsh
(Address) Parma

15. Filed 3/10, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 9, 1930
that I last saw her alive on Feb 9, 1930
and that death occurred, on the date stated above, at 6 45 P m.
The CAUSE OF DEATH* was as follows:
Cerebral embolus
Congenital Debility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J J Sarazin, M. D.
2/9 1930 (Address) Nyssa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Parma Ida — Date of Burial 2/11 1930
20. Undertaker Frank Chapman — Address Parma

RECEIVED OCT 23 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69527

Dr. J. J. Sarazin
Nyssa

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Edith Laurine Marsh who died at Parma, Idaho Feb. 9, 1930
Cause of death given as "Cerebral Embolus"

Information DESIRED in order to complete certificate:

STATE PRIMARY CAUSE. INJURY AT BIRTH? CONGENITAL DEBILITY? VIOLENCE?

PLEASE ANSWER BELOW:

Congenital Debility

J. J. Sarazin M.D.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69528

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 19

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

15-a

2. FULL NAME Gertrude Irene Hawley

(a) Residence. No. ..... Caldwell Rt #2 ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 21 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Caldwell (State or country) Idaho

PARENTS

10. NAME OF FATHER E. C. Hawley

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) .....

14. Informant Glen S. Beebe
(Address) Caldwell R. 2.

15. Filed 2-11-, 1930. John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 21, 1930, to Feb. 6, 1930
that I last saw her alive on Feb. 5, 1930
and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:
Incomplete cerebral development.
..... (duration) ..... yrs. ..... mos. 15 ds.
CONTRIBUTORY (Secondary) Malformed-case and
relations of mother during gestation
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) C. M. Whittenberger M.D., M. D.
Feb 7, 1930 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenleaf	2/7/ 1930
20. Undertaker	Address
Lathey & Friends.	Greenleaf Idaho.

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Leave no space blank. Write plainly. Use ink. Do not use lead pencil. Do not use abbreviations. Do not use ditto marks. Answer every question. If unknown, say so. Do not leave any question unanswered. Do not write in margins. Do not fold. Do not roll. Do not mutilate. Do not write in this space. Do not write in this space. Do not write in this space

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69529

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1621

2. FULL NAME Edward Reese Young

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 7" - 1929

7. AGE Years | Months 4 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Ida

PARENTS

10. NAME OF FATHER Thomas S Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jordan Valley Ore
12. MAIDEN NAME OF MOTHER Minnie A Gabus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Thos S Young
(Address) Caldwell Ida RD #4

15. Filed 2-14-, 1930. John S. Meyes. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw him alive on November 30, 1930
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:
Intestinal Indigestion

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Patent foramen ovale
(Blue baby) (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C R Whittenberger D.C. M. D.
Feb 13, 1930 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 2-14" 1930

20. Undertaker: C V Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69530

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

90

2. FULL NAME William Henry Garrett
(a) Residence. No. Middleton Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20

7. AGE Years 83 Months 7 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER William Garrett Sr
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Lucretia Garrett
(Address) Middleton Ida

15. Filed 2-21-, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1930, to ....., 19..
that I last saw him alive on Feb. 3, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) Thos E Mangum, M. D.
Feb. 19, 1930 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Ida
Date of Burial: Feb 17 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 65531

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Mrs Margaret Adelaide Allison
(a) Residence. No. Canyon County Patients St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Washington Allison

6. DATE OF BIRTH (month, day and year) Apr 9 1851

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
78	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomv ille N Y

PARENTS

10. NAME OF FATHER Zalmon Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Caroline Couse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs L.H.Lusk
(Address) 1401 South 8" Caldwell Ida

15. Filed 2-18-, 1930 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16-30 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1929, to Feb 16, 1930
that I last saw her alive on Feb 16, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Uremia.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
2/17, 1930 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery
Date of Burial: 2-18-30 19

20. Undertaker: Paul L.Case
Address: Caldwell Ida

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69532

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No.
Primary Registration District No. 2005
Local Registrar's No. 24

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Mrs Nellie Dere

(a) Residence. No. 916 9th Ave So St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Philip Dere

6. DATE OF BIRTH (month, day and year) May 30 1886.

7. AGE: Years 43. Months 9 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Teacher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Columbus Indianna

PARENTS

10. NAME OF FATHER Jno A. Thompson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Eustine Sims
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indianna

14. Informant Neel Thompson
(Address) Caldwell. Idaho. R.F.D.

15. Filed 3-24-1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8.40 A M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dere was in a coma since accident

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Case, M. D.
Feb 21-30, 19 (Address) Coroner
Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	Feb 24-30
20. Undertaker	Address
Paul L. Case	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69533

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Wm H. Raybourn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 3 1865

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	--	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: W B Raybourn

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Julia Jennings

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Julia Raybourn
(Address): 2012 Arthur Caldwell Ida

15. Filed 2-21-, 1930 John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 20-30 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Feb 20, 1930

that I last saw him alive on Feb. 20, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.

2/20, 1930 (Address) Caldwell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho

Date of Burial: 2-23-30 19

20. Undertaker: Paul L. Case

Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69534

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 9005
Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mrs Clara Sincel

(a) Residence. No. Odd Fellows Home St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marshall Mich

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Viola H Price
(Address) Caldwell Idaho

15. Filed 2-25, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22-30 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1925, to Feb 22, 1930
that I last saw her alive on Feb 22, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) Senile Dementia
..... (duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
2/25, 1930 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Hill Cemetery
Date of Burial 2-25-30 19

20. Undertaker Paul L. Case
Address Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69535

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

49

2. FULL NAME Henry Milton Day
(a) Residence. No. 1816 Logan St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 8 —

7. AGE: Years 78, Months 3, Days 15 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Lawrence Co New York.

PARENTS

10. NAME OF FATHER Day.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Lawrence Day
(Address) Boise Idaho

15. Filed 3-1-, 1930. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. - 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 23, 1930
that I last saw him alive on Feb 22, 1930
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris.
Had 4 attacks since Jan 30 30
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M.D.
2/25, 1930 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roswell — Date of Burial: 2-26 1930

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69536

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 32

74a

2. FULL NAME Frank Pierce Smith
(a) Residence. No. 1017 Main St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 26 - 1860

7. AGE: 69 Years, 2 Months, 8 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Davenport Iowa

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Dora E Smith
(Address) Main St

15. Filed 3-6-, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 4 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1928, to March 4, 1930
that I last saw him alive on March 3, 1930
and that death occurred, on the date stated above, at 1-30 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Arterial sclerosis from many years of infected teeth
(duration) ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C R Whatenburger M. D.
Mar. 6, 1930 (Address) Caldwell, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 3-6 1930

20. Undertaker: L. V. Peckham Address: Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69537

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Thomas W. Griggs

(a) Residence. No. Caldwell Rfd # 2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Maud Griggs

6. DATE OF BIRTH (month, day and year) Dec 5 1862

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	2	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER: Wm P. Griggs

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Calvin Griggs
(Address) Rfd 2 Caldwell

15. Filed 3-4-, 1930 - John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1930, to Mar 2, 1930

that I last saw him alive on Mar 2, 1930

and that death occurred, on the date stated above, at 8 Am

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Double

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Flu —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J D Farrer, M. D.

3/3, 1930 (Address) Caldwell Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill

Date of Burial: Mar 5 1930

20. Undertaker: Paul L. Case

Address: Caldwell, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69538

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No.)
Local Registrar's No. 30

(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Adelaide L Brown

(a) Residence. No. 602 Dearborn St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 17 - 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ozark Mo.

PARENTS

10. NAME OF FATHER Andrew Lawing
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ozark Mo.
12. MAIDEN NAME OF MOTHER Angeline Weaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Murphysburrough Kentucky

14. Informant Jessie M. Cook
(Address)

15. Filed 3-5-, 1930 John S. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 - 1 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Mar 1, 1930
that I last saw h[illegible] alive on Mar 1, 1930
and that death occurred, on the date stated above, at 5.25 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of cervix with metastasis to bowels & liver
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Microscope
(Signed) C. M. Montgomery, M. D.
3/4, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	3-3. 1930
20. Undertaker	Address
C. V. Peckham.	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 13 1930

PLACE OF DEATH

County of Canyon

City of Caldwell

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 69539

Local Registrar's No. 29

44

2. FULL NAME Charles F. Metcalf

(a) Residence. No. R. F. D. Caldwell St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26, 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	11	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hyde Park Utah

PARENTS

10. NAME OF FATHER Anthony Metcalf

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Yorkshire England

12. MAIDEN NAME OF MOTHER Mary Reeder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Charles Metcalf

(Address) R. F. D. Caldwell

15. Filed 3-4-, 1930. John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1914, to Mar 1, 1930 that I last saw h[e] alive on Mar 1 -, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Operation Cancer Stomach
Feb -24-30-
Stomach Failed To Operate

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulcer Stomach -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of Feb 24/30

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) J. D. Faulkner, M. D.

Mar 3, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	March 4 1930
20. Undertaker	**Address**
Paul L. Case	Caldwell, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69540

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 28

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Alfred Lewis De Priest

(a) Residence. No. Caldwell Rfd # 2 St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. ~~If married, widowed, or divorced~~ ~~HUSBAND~~ of (or) ~~WIFE of~~ Mrs Mary De Priest

6. DATE OF BIRTH (month, day and year) Dont Know for sure

7. AGE Years: Approx 52 | Months: ✓ | Days: ✓ | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Mary De Priest

(Address) Caldwell Rfd #2

15. Filed 3-1-, 1930. John S. Meyer. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 27 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 27, 1930

that I last saw her alive on Feb 27, 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pyorrhea Alveolaris

..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Stethoscope

(Signed) W. Montgomery X Roy, M. D.

3/1, 30 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: Mar 2 1930

20. Undertaker: Paul L. Case | Address: Caldwell, Idaho

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 3

DO NOT WRITE IN THIS SPACE
State File No. 69541

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No.
Primary Registration District No. 1005
Local Registrar's No. 33
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

73

2. FULL NAME Floyd E Smith

(a) Residence. No. 810 Dearborn St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs Ora . Smith

6. DATE OF BIRTH (month, day and year) April 1, 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	11	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Unknown Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs James Walker
(Address) Caldwell, Idaho

15. Filed 3-11-, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 9, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1926, to March 9, 1930
that I last saw him alive on March 9, 1930
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:
Syringomyelia
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical history
(Signed) W. W. Montgomery M. D.
3/11, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: March 11, 1930
20. Undertaker: Paul L. Case — Address: Caldwell, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC[illegible] MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69542

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

118B

2. FULL NAME Maclyn Cutsforth
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21-27

7. AGE Years 2 Months 2 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Soda Springs Ida

PARENTS
10. NAME OF FATHER S. M. Cutsforth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Bessha Bump.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Dakota

14. Informant S. M. Cutsforth
(Address) Soda Springs Ida

15. Filed 2-28, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to Feb 28, 1930
that I last saw him alive on Feb 28, 1930
and that death occurred, on the date stated above, at 10 35 P m.
The CAUSE OF DEATH* was as follows: Intestinal Obstruction - probably in ileum
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) none
..... (duration) ..... yrs. ..... mos. 0 ds.

18. Where was disease contracted if not at place of death? Near Soda Spgs Ida
Did an operation precede death? no Date of 0
Was there an autopsy? no
What test confirmed diagnosis? 0
(Signed) Russell Tigert, M. D.
2/28, 1930 (Address) Soda Spgs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 3-1-1930

20. Undertaker E. L. Whiteman — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69543

PLACE OF DEATH

County of Caribou

City of Soda Springs

Registration District No. 82

Primary Registration District No. 2159

Local Registrar's No. 76

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Oscar Sam Johnston

(a) Residence. No. Big Piney Wyoming St. Big Piney, Wyo.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None

6. DATE OF BIRTH (month, day and year) 1870

7. AGE Years 60 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher & Stockman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Van Buren Co.

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Columbus Johnston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Anna Bell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant G. C. Johnston
(Address) Big Piney, Wyo.

15. Filed 2-27, 1930 Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Feb. , 1930

that I last saw him alive on Feb. 27, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease - Chronic cystitis due to enlarged prostate, septic condition due to retention

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2-7-30

Was there an autopsy? 0

What test confirmed diagnosis? Physical Examination

(Signed) Ellis Kartchy, M. D.

2/27/30, 19.... (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Big Piney Wyo. Date of Burial Mch. 4 1930

20. Undertaker G. D. Whetman Address Soda Springs Ida

RECEIVED SEP 8 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69543

Dr. E. Kackley
Soda Springs

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Oscar Sam Johnston whoddied at Soda Springs, Idaho on Feb. 27, 1930
Cause of death given as "Organic Heart Disease."
Information DESIRED in order to complete certificate:

PLEASE STATE THE CAUSE FOR THE RELIEF OF WHICH THE OPERATION WAS PERFORMED.

PLEASE ANSWER BELOW:

Chronic Cystitis due to enlarged Prostrate, septic condition due to retention. Think this caused the trouble in the heart, however, I am not sure of this asI had never known himtill he came here for an operation but atthat time he hada profound Mitral Condition with all theassociated heart trouble.

Ellis Kackley

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69544

PLACE OF DEATH

County of Caribou
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
Local Registrar's No. 5
(If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Beverly Peterson

(a) Residence. No. ..... St. Grace Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year) 9-1-1929.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hyrum Peterson

9. BIRTHPLACE (city or town) Grace
(State or country) Idaho

PARENTS

10. NAME OF FATHER Hyrum Peterson
11. BIRTHPLACE OF FATHER (city or town) Gunnison
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Flora Perry
13. BIRTHPLACE OF MOTHER (city or town) Mill
(State or Country) Utah

14. Informant Hyrum S Peterson
(Address) Grace Idaho

15. Filed 2/19, 1930 Dr Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to Feb. 19, 1930
that I last saw her alive on Feb. 19, 1930
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Purpura Hemorrhagica
(Status Epilepticus - Hemorrhagic)
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Measles
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? Grace, Ida
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Ex
(Signed) Russell Tigert, M. D.
2/19, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal	Date of Burial
Grace Idaho	2/20 1930

20. Undertaker	Address
John Bagley	Grace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69545

County of Caribou

City of Soda Springs 2dd

Registration District No. 82

Primary Registration District No. 2159

Local Registrar's No. 354

(No. Caribou Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

188 W

2. FULL NAME Ingvald Miles

(a) Residence. No. Grace Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State) Grace, Idaho

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Miles.

6. DATE OF BIRTH (month, day and year): Aug 20 - 1900

7. AGE: Years 29 | Months 5 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Soda Springs Idaho

PARENTS

10. NAME OF FATHER: Daniel Miles

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Jane Walker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Wm Miles

(Address): Grace Ida

15. Filed 2-2-, 30 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY That I attended deceased from Feb. 1, 1930, to Feb. 1, 1930, that I last saw h[illegible] alive on Feb. 1, 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows: Shock Pulmonary trauma Accidental Run over by sleigh & team of horses

(duration) yrs. mos. 1/4 ds.

CONTRIBUTORY (Secondary): None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Grace, Idaho

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exa

(Signed) Russell Tigert, M. D.

Feb 7, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grace Ida — Date of Burial: 2-4-1930

20. Undertaker: C. L. Whiteman — Address: Soda Springs

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69546

PLACE OF DEATH
County of Cassia
City of Malta

Registration District No. 119
Primary Registration District No. 2198
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

75

2. FULL NAME Thomas Lloyd

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Lloyd

6. DATE OF BIRTH (month, day and year) May 1, 1868

7. AGE Years 63 Months 8 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Thomas Lloyd

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Levon Lloyd
(Address) Malta Idaho

15. Filed Mar 10, 1930 C. Slater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1928 to Jan 14, 1930
that I last saw him alive on Jan 13, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows: Paralysis Agitans
..... (duration) 2 yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) C. Slater, M. D.
Mar 11, 1930 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shanish Fork Ut. Date of Burial Jan. 18 1930

20. Undertaker D. E. Johnson Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69547

PLACE OF DEATH

County of Cassia
City of Moulton
Registration District No. 119
Primary Registration District No. 2199
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

141

2. FULL NAME Mary S Moeller

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Moeller

6. DATE OF BIRTH (month, day and year) Oct 22, 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	3	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Louie Augustine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Mary Deo
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant C. Moeller
(Address) Moulton Idaho

15. Filed Mar 10 1930 C. F. Sales Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Jan 27, 1930
that I last saw her alive on Jan 25, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Fibroid Tumor of uterus with Abscess,
(duration) One yrs. mos. ds.
CONTRIBUTORY (Secondary)
None (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? At place
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) C. E. Bales, M. D.
Mar 10 1930 (Address) Malta Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Jan 29 1930
20. Undertaker	Address
W. E. Johnson	Burley

FORM V. S. No. 4-2 M. 1-19. RECEIVED MAR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ....., ... St.)

File No. 69548

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Severn Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Cauc

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1863 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business or establishment in which employed (or employer): Pool Hall and Food Hall

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed March 5 1930 Mildred S. Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 17 (Day) 1930 (Year) 79B

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1930, to Feb 17 1930, that I last saw him alive on Feb 17 1930, and that death occurred on the date stated above, at 8 05 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Purulent Bronchitis

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) O M Husted M. D.

2/17 1930 (Address) Elk River, Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: E. D. Hunt

DATE OF BURIAL: Feb 19 1930

20. UNDERTAKER: [illegible]

ADDRESS: Elk River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED MAR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ..... St.)

File No. 69549

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Webb Stillwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: August (Month) 21 (Day) 1887 (Year)

7. AGE: 42 Yrs. 5 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Roulette Penn.

10. NAME OF FATHER: Perry L. Webb

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Margaret Sullivan

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo De Forrest Stillwell

(Address) Elk River Idaho

15. Filed March 5 1930 Mildred Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 27 (Day) 1930 (Year) 11a

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, to Jan 27 1930, that I last saw her alive on Jan 25 1930 and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O M Husted M. D.

Jan 27 1930 (Address) Elk River, Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene Idaho

DATE OF BURIAL: Jan 30 1930

20. UNDERTAKER: O Sullivan

ADDRESS: Spokane

License Idaho 169 - Wash 322

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

REC'D MAR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
File No. 69550
Registered No. 2

1. PLACE OF DEATH
County of Clearwater
City of Elk River (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Maude Vail
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 13 (Day) 1880 (Year)

7. AGE: 49 Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rochester Minnesota

10. NAME OF FATHER: J. R. Vail

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: unobtainable

13. BIRTHPLACE OF MOTHER (State or Country): 11

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Charlotte Woodward
(Address) Elk River, Idaho

15. Filed March 5 1930 Mildred S. Standley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, to Jan 28 1930 that I last saw her alive on Jan 28 1930, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar - Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary): acute nephritis
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) O M Austad M. D.
Jan 29 1930 (Address) Elk River Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Ellenberger | ADDRESS: Spokane Wn

Ida Licen 169 - Wash 322

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69552

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 17

(No.) 11a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Hubert Cavanagh

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Orofino Idaho
(State or country)

PARENTS

10. NAME OF FATHER James H. Cavanagh
11. BIRTHPLACE OF FATHER (city or town) Canada
(State or Country)
12. MAIDEN NAME OF MOTHER Frances Wolfinger
13. BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country)

14. Informant Frances Wolfinger Cavanagh
(Address) Orofino

15. Filed 3/22, 1930 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 21st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 1930, to 2-21, 1930
that I last saw him alive on 2-21st, 1930
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:
Pneumonia - with Influenza
Relapse -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Teething
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) H. H. Robertson, M. D.
2-22, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	Feb 23 1930
20. Undertaker W. D. Pinson	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69553

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 16

178

PLACE OF DEATH

County of Clearwater
City of Orofino
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roy Lavon Moffet

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Moffet
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Laura Larson
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Utah

14. Informant John Moffet
(Address) Pierce Ida

15. Filed 2/10, 1930 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 11:30 P m.
The CAUSE OF DEATH* was as follows:

Suffocated with smoke in a
Burning house

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. A. Shaw Coroner, ~~M. D.~~
2/10, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Kamiah Ida	
20. Undertaker W. A. Shaw	Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69554

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 15

174

PLACE OF DEATH

County of Clearwater
City of Orofino
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene S. Rosebough

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 25 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester Ida

PARENTS

10. NAME OF FATHER Floyd Rosebough
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chris Kansas under
12. MAIDEN NAME OF MOTHER Christina Lundus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Floyd Rosebough
(Address) Winchester

15. Filed 2/10, 1930. V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11:30 p m.
The CAUSE OF DEATH* was as follows:

Suffocate from smoke from burning house

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) V. A. Shaw Coroner, M. D.
2/10, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Winchester Ida	Feb 11 19

20. Undertaker	Address
V. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69555

PLACE OF DEATH

County of Clearwater

City of Ahsahka

Registration District No. 93

Primary Registration District No. 2157

Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1a

2. FULL NAME Soloman Wheeler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M,

4. COLOR OR RACE I,

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) ~~Feb~~ Mar 16 1917

7. AGE 12 Years 12 Months 11 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ahsahka

PARENTS

10. NAME OF FATHER Harry Wheeler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pendleton Ore,

12. MAIDEN NAME OF MOTHER Ida James

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stites Ida

14. Informant Harry Wheeler
(Address)

15. Filed Feb 8, 1930 W. A. Wheeler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 19.., to Feb. 6, 1930 that I last saw him alive on Jan. 29, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (duration) ..... yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) R. T. Hopkins, M. D.

2/9/30, 19.. (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ahsahka — Date of Burial Feb 8 1930

20. Undertaker W. D. Pinson — Address

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69556

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 13

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

91B

2. FULL NAME John Hagenson

(a) Residence. No. ..... St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? 30 yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Norway
(State or country)

PARENTS

10. NAME OF FATHER John Hagenson
11. BIRTHPLACE OF FATHER (city or town) Norway
(State or Country)
12. MAIDEN NAME OF MOTHER Martha A. Emmonsen
13. BIRTHPLACE OF MOTHER (city or town) Norway
(State or Country)

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Feb 3, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27, 1929, to February 1, 1930
that I last saw him alive on January 31, 1930
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:
General arteriosclerosis

(duration) 5 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with cerebral arteriosclerosis (duration) 5 yrs. ? mos. ? ds.

18. Where was disease contracted, if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) John Irvine McElwaney, M. D.
February 1, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cemetery, No. IDaho San.	Feb. 1 1930
20. Undertaker	Address
F. A. Billberg, Hosp. Attd.	Orofino, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

PLACE OF DEATH

County of Clearwater

City of Ahsahka

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2187

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69557

Local Registrar's No. 12

164

2. FULL NAME Harriett Ann Patty

(a) Residence. No. Ahsahka St.

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Patty

6. DATE OF BIRTH (month, day and year) Sept 1st 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	4		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Eaton Indiana

PARENTS

10. NAME OF FATHER Joseph Peter Hance

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ Indiana

12. MAIDEN NAME OF MOTHER Mary Jan Harris

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Palmer Patty (Husband)

(Address) Ahsahka - Idaho -

15. Filed Feb 1, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to 2-1, 1930

that I last saw her alive on August, 1928

and that death occurred, on the date stated above, at 7:30 a m.

The CAUSE OF DEATH* was as follows:

Old Age

Arteriosclerosis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Flu

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Jeff Peterson M. D.

2-1, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino	2/3 19
20. Undertaker W. A. Shaw	Address Orofino

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69558

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 18
Primary Registration District No. 2186 Local Registrar's No. 98
(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Dolores Lee

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	Wh	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Challis Ida
(State or country)

PARENTS

10. NAME OF FATHER David Lee Jr.
11. BIRTHPLACE OF FATHER (city or town) Ida.
(State or Country)
12. MAIDEN NAME OF MOTHER Edla Vandenmark
13. BIRTHPLACE OF MOTHER (city or town) Ida
(State or County)

14. Informant Edla Vandenmark
(Address) Challis, Idaho

15. Filed Feb 28, 1930 Edna McKenna
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Born at 4 mo. Cause not known

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. Bradley, M. D.
2/20, 1930 (Address) Challis

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69559

PLACE OF DEATH
County of Custer
City of Challis
Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 97
(No. 1) (If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Thomas Kerr

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	wt	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Apr 20 1910

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) High School
(c) Name of employer

9. BIRTHPLACE (city or town) Challis, Idaho
(State or country)

PARENTS

10. NAME OF FATHER James M Kerr
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Rosa Jensen
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Mrs James Calvin
(Address) Challis Idaho

15. Filed Feb 18, 1930. Elva McKinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/14, 1930, to 2/17, 1930
that I last saw him alive on 2/17, 1930
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal meningitis
Epidemic type
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C S Murphy, M. D.
2/17, 1930 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Challis, Idaho	Feb. 18 1930
20. Undertaker Geo. R. Garnier	Address Mackay, Ida.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69560

PLACE OF DEATH
County of Elmore
City of Near King Hill Ida
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No. 65-A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Noel Constance Heath
(a) Residence. No. Near King Hill Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 25 - 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Forest Ranger & Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Seth Heath
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary S. Jolley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Wm. Heath
(Address) King Hill Idaho.

15. Filed 2-18 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 13, 1930
that I last saw him alive on Feb 13, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myelocytic Leukemic Myelosis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. L. Sprendeling M. D.
2-14-30 19 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Mt. Home Idaho	2-16 1930

20. Undertaker G. C Zacher Address Mt Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69561

PLACE OF DEATH
County of Franklin
City of Glendale
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

20-B

2. FULL NAME Valdo Porter Webster

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 9 30

7. AGE	Years	Months	Days	If LESS than 1 day,
			I	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Glendale

PARENTS

10. NAME OF FATHER Asa L. Webster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Glendale
12. MAIDEN NAME OF MOTHER Racheal Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Preston Idaho

14. Informant Asa L. Webster
(Address) Glendale Idaho

15. Filed , 19 . Registrar G. R. Cutler

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb. 10, 1930
that I last saw him alive on Feb 10, 19
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Undetermined.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. R. Cutler, M. D.
2-12-, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	Feb. 11 1930

20. Undertaker M. W. Hendricks Address Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
3.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69562

PLACE OF DEATH
County of Franklin
City of Mapleton

Registration District No. 27
Primary Registration District No. 219
(No. [redacted])
(If death occurred in a hospital or institution, give name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME Anna Rebecca Sharp

(a) Residence. No. [redacted] St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work BABY
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mapleton Idaho

PARENTS

10. NAME OF FATHER Joseph T. Sharp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Toolle Utah
12. MAIDEN NAME OF MOTHER Anna Woodhead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J.T. Sharp
(Address) Mapleton

15. Filed Feb-25, 1930. [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr. 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 22, 1930, to Febr. 24, 1930
that I last saw [redacted] alive on Febr. 24, 1930
and that death occurred, on the date stated above, at 3 p. m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(duration) [redacted] mos. 4 ds.
CONTRIBUTORY (Secondary) Pneumo [redacted]
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? -
What test confirmed diagnosis? Clinical Symptoms
(Signed) [redacted], M. D.
Feb. 25, 1930 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Feb. 25 1930

20. Undertaker M.W. Hendricks Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69563

PLACE OF DEATH
County of Franklin
City of Treasarton

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 122)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Alphonse Vidmer

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Swiss	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Elizabeth Vidmer

6. DATE OF BIRTH (month, day and year) Oct. 5. 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	4	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Attorney P. M. Condie
(Address) Preston, Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-1- , 1929, to 2-14 , 1930
that I last saw h... alive on 1-13 , 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Cirrhosis of Liver
(duration) several yrs. yrs. mos. ds.
CONTRIBUTORY (Secondary) Gastric Hemorrhage.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston, Idaho	2-16 19 30

20. Undertaker	Address
M. W. Hendricks	Preston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

PLACE OF DEATH
Franklin
County of .....
City of Glenco

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 69564

Local Registrar's No. 131

2. FULL NAME Slsie Catherine Larsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter Larsen

6. DATE OF BIRTH (month, day and year) Oct I2 I846

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Mads Madsen
11. BIRTHPLACE OF FATHER (city or (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Anna Marie Madsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Nevada Larsen
(Address) Glenco Idaho

15. Filed Feb. 24, 1930. G. P. Quick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 - 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to 2-16, 1930
and that I last saw her alive on 2-16, 1930
and that death occurred, on the date stated above, at noon m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. P. Quick, M. D.
Feb. 24, 1930 (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Minkcreek Idaho	Feb, 22 30

20. Undertaker M.W. Hendricks Address Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69565

Local Registrar's No.

161 B

PLACE OF DEATH

County of Franklin

City of Clifton Ida

Registration District No. 27

Primary Registration District No. 2119

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Chadwick

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clifton Ida

PARENTS

10. NAME OF FATHER: Earl Chadwick

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Whitney Ida

12. MAIDEN NAME OF MOTHER: Amy May Saint

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clifton Ida

14. Informant: Earl Chadwick

(Address): Whitney Ida

15. Filed Feb 27, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 26 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25, 1930, to 2-26, 1930

that I last saw her alive on Feb. 26, 1930

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Sub dural hemorrhage.
Instrumental delivery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.

Feb. 27, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney Ida	Feb. 28 1930

20. Undertaker — Address: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69566

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4

2. FULL NAME William E. Fackrell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 9, 1926

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
3	3	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston, Idaho

PARENTS

10. NAME OF FATHER Forest A. Fackrell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Randolph, YUtah

12. MAIDEN NAME OF MOTHER Wealthy Sutton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paris, Idaho

14. Informant F. A. Fackrell
(Address) Preston, Ida

15. Filed Feb. 8, 1930 A. R. Culley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH J. Febr. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Febr. 4, 1930
that I last saw him alive on Febr. 3, 1930
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Scarlet fever —

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Septic Adenitis and Tonsilitis (duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.

Febr 4, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston, Idaho

Date of Burial: 2/ 6/ 1930

20. Undertaker: M. W. Hendricks

Address: Preston,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69567

County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B1

2. FULL NAME Maria Louise Sponberg

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lars Fredric Sponberg

6. DATE OF BIRTH (month, day and year) Aug 30 1837

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
92	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER John Erick Lindstead

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Agna B. Linstead

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Thomas Sponberg
(Address) Preston

15. Filed Feb. 8, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 1930, to 2-6, 1930
that I last saw h[illegible] alive on 2-6, 1930
and that death occurred, on the date stated above, at 7:30 p.m.
The CAUSE OF DEATH* was as follows:
Uremia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Idaho	Feb. 8 19 30

20. Undertaker M. W. Hendricks Address Preston

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69568

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a.

2. FULL NAME Henby Cartwright

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 14 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Had none at present
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John Cartwright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Cartwright
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Albert Cartwright
(Address) Richmond Utah

15. Filed Feb. 19, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16, 1930, to 2-17, 1930
that I last saw h~~e~~ alive on 2-17, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E.S. Mulford, M. D.
2-19, 1930 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho Feb. — Date of Burial: 20 30 19

20. Undertaker: M.W. Hendricks — Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69569

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Lorna Hodges

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 6 30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work BABY
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Geo Edward Hodges
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewiston Utah
12. MAIDEN NAME OF MOTHER Verda Larsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clifton Idaho

14. Informant Geo. E. Hodges
(Address) Preston

15. Filed Feb. 25, 1930 A. P. Miller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 18, 1930, to Febr. 23, 1930
that I last saw him alive on Febr 22, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows: General Septicaemia from infection of foot
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Infancy 3 weeks
locking 4 days.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. Stutz, M. D.
Febr 24, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Feb. 25 30

20. Undertaker	Address
M. W. Hendricks	Preston

MARGIN RESERVED FOR BINDING
KINDLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69570

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Millie Carolina Maughan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph W. Maughan

6. DATE OF BIRTH (month, day and year) June 8 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John Utley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) S Carolina

12. MAIDEN NAME OF MOTHER Eoizabeth Rutledge

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N Carolina

14. Informant Della Chadwick
(Address) Preston Idaho

15. Filed Feb. 14, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1929, to 2/12, 1930
that I last saw her alive on Oct 31, 1929
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
At my appointment Patient died of Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Holden, M. D.

2/13, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan Utah — Date of Burial: Feb. 14 30

20. Undertaker: M. W. Hendricks — Address: Prston

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69572

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lynn Wm. Fryer 24

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Wm. Fryer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davey Utah
12. MAIDEN NAME OF MOTHER Jennie Ericksen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minkcreek Idaho

14. Informant Wm. Fryer
(Address) Preston

15. Filed Feb 19, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2-18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16, 1930, to 2-18, 1930
that I last saw him alive on 2-18, 1930
and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:
Follicular tonsilitis
Double otitis Media
Streptococcus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Meningitis Streptococcus
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
2-19, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	Feb 21 1930

20. Undertaker M. W. Hendricks Address Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69573

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Mark Mary Jones

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white married
5. Single, Married, Widowed, Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lavina T. Jones

6. DATE OF BIRTH (month, day and year) Jan 3 1863

7. AGE Years 67 Months 1 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS

10. NAME OF FATHER Nathanal V. Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York St

12. MAIDEN NAME OF MOTHER Carolinia Garr

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indania

14. Informant Mrs Mark V. Jones
(Address) Preston Idaho

15. Filed , 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) ✓ (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Mch~~ Feb, 19 , to Mch, 1930
that I last saw him alive on Feb, 1930
and that death occurred, on the date stated above, at Fairview
The CAUSE OF DEATH* was as follows:
Heart failure
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
3-4- , 1920 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Utah Date of Burial Mar 3 30 19

20. Undertaker M. W. Hendricks Address Preston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69575

PLACE OF DEATH

County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kittie B Webster 90

(a) Residence. No. Emmett 2da St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) Aug-27-1847

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
82	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10. NAME OF FATHER Isaac Burnett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cincinnati Ohio
12. MAIDEN NAME OF MOTHER Rebecca Bryant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cincinnati Ohio

14. Informant Mrs Z P Stacy
(Address) Emmett Ida

15. Filed 2-22 1930 J H Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1929, to Feb 22, 1930
that I last saw her alive on Feb 20, 1930
and that death occurred, on the date stated above, at 12 M m.

The CAUSE OF DEATH* was as follows:
Aortic Stenosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Many Complications
Diabetes also Senile Dementia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J H Reynolds M. D.
2-22-, 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Omaha Nebr.	Feb 28 1930

20. Undertaker	Address
Summers Funeral Home	Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69577

PLACE OF DEATH

County of Ada

City of Boise

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Mrs Olive May Timson

(a) Residence. No. Emmett Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas H Timson

6. DATE OF BIRTH (month, day and year): Mch 18 1902

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
27	11	- -	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rexburg Ida

PARENTS

10. NAME OF FATHER: Wm Henry Bills

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nancy May Hope

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Chas H Timson
(Address) Emmett Idaho

15. Filed, 19 J K Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 18 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb.17, 1930, 19, to, 19

that I last saw h alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Brain Abcess

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Mastoditis

(duration) yrs. 11 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid

(Signed) [signature], M. D.

Feb. 19, 1930 (Address) 209 Eastman Bld Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho

Date of Burial: Feb 20-30

20. Undertaker: Paul L.Case

Address: Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69578

PLACE OF DEATH
County of Ada
City of Emmett — Registration District No. ____ Primary Registration District No. ____ Local Registrar's No. ____
(No. ____ If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Annie B. Frost

(a) Residence. No. ____ St. ____ (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
fem	white	married

3a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of S. A. Frost

6. DATE OF BIRTH (month, day and year) July 14 - 1883

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
46	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Robert Harvey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant J. G. Frost
(Address) Emmett Idaho

15. Filed 2/13, 1930. J. G. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to Feb 9 to 9, 1930
that I last saw her alive on Feb 9 23, 1930
and that death occurred, on the date stated above, at 1-20 a m.
The CAUSE OF DEATH* was as follows:
Apoplexia
Probably Cerebral hemorrhage
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. 3 ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) J. G. Reynolds, M. D.
2/13, 1930 (Address) ____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	2/14 1930
20. Undertaker D. Parkinson	Address Emmett Idaho

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69579

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 488)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Jackson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	86			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sequashua Co. Tenn.

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant
(Address)

15. Filed 2/11, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Feb 10, 1930
that I last saw him alive on Feb 9, 1930
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
2/11 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 2/11 1930
20. Undertaker: O Buckner — Address: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible]D MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69580

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

11B

2. FULL NAME Joseph Matthew Bate

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1 - 1844

7. AGE 85 Years | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Stephen H. Bate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Julia Hackman
(Address) Emmett Idaho

15. Filed 2/12, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from I saw this fellow Feb 10, 1930
that I last saw him alive on Feb 10th, 1930
and that death occurred, on the date stated above, at 8 pm m.
The CAUSE OF DEATH* was as follows:
Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds M. D.
2/12, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 2/12 1930

20. Undertaker: C D Bucknum
Address: Emmett Idaho

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69581

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No. 6
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

124

2. FULL NAME Myrtle Florence Howard

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16 - 1917

7. AGE Years: 12 Months: 8 Days: — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: Ben D. Howard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Dakota
12. MAIDEN NAME OF MOTHER: Olive Morehouse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Ben D. Howard
(Address): Emmett Idaho

15. Filed 2/18, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to Feb 16, 1930
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 1-15-P m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Scarlet fever

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? clinical evidence
(Signed) Wm T. Drysdale, M. D.
Feb 18, 1930 (Address) New Plymouth Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett
Date of Burial: 2/18 1930

20. Undertaker: C D Buckner
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 30582

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 204) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Farrow Mills

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of E. L. Mills

6. DATE OF BIRTH (month, day and year) Apr 23 - 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelbyville Missouri

PARENTS

10. NAME OF FATHER Alex Farrow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Emeline Kenkel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Leslie Mills
(Address) Emmett Idaho

15. Filed 2/20, 19.... J. H. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from at time of death 2-18-, 1930
that I last saw h... alive on 2-18-30, 19...
and that death occurred, on the date stated above, at 7-20 a
The CAUSE OF DEATH* was as follows:
Cardiac Condition
probably Coronary Occlusion
death upon sudden

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. H. Reynolds M. D.
2/20, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 2/21 1930

20. Undertaker: O. S. Bucknum — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 REC... MAR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gurley

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. ..... St.)

File No. 69584

Registered No. 122

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE 45 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Anderson

(Address) Fairfield Ida

15. Filed 3/28 1930

J H Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

101 B

16. DATE OF DEATH February (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1929, to Feb 28 1930, that I last saw him alive on 2-28- 1930, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Gastric hemorrhage, pneumonia - with Complications

..... (Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.

..... 19 ..... (Address) Gurley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairfield Ida

DATE OF BURIAL: 3/4 1930

20. UNDERTAKER: A E Thompson

ADDRESS: Gurley

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. 5-25 M. 1-19. REC MAR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Bliss

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 24

(No. , St.)

File No. 69585

Registered No. 222

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Bart Stratton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct. (Month) 23 (Day) 1929 (Year)

7. AGE: Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Bliss Ida.

10. NAME OF FATHER: Henry G. Stratton

11. BIRTHPLACE OF FATHER (State or Country): Kanarra Utah

12. MAIDEN NAME OF MOTHER: Lula M. Pruett

13. BIRTHPLACE OF MOTHER (State or Country): Boise Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. G. Stratton

(Address) Bliss Ida.

15. Filed 2/7 1930

J H Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

100a

16. DATE OF DEATH: Feb. (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1930, to Feb 6 1930, that I last saw him alive on Jan 24 1930 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.

19 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding Ida

DATE OF BURIAL: 2-8- 1930

20. ~~UNDERTAKER~~: Thompson's

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAR 6 1930

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

File No. 69586

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. John J. Jentges

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 13 (Day) 1895 (Year)

7. AGE: 35 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Mike Hillenburg

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Philomine Hupfeld

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Jentges

(Address) Cottonwood, Idaho.

15. Filed Feb. 14 1930 W. F. Orr M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1930 to Feb. 12 1930 that I last saw her alive on Feb. 12 1930 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to Ruptured Ectopic pregnancy.

(Duration) ..... Yrs. ..... mos. 3 hrs ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Orr, M. D.

2/14 1930 (Address) Cottonwood.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green Creek, Idaho. DATE OF BURIAL: 2/15 1930

20. UNDERTAKER: Father Baedecker ADDRESS: Green Creek, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 6 0587

PLACE OF DEATH

County of Idaho

City of Fenn

Registration District No. 103

Primary Registration District No. 2187

Local Registrar's No. 5

161a

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baley Leslie

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Baley

6. DATE OF BIRTH (month, day and year): Feb. 28 - 1930

7. AGE — Years | Months | Days | If LESS than 1 day, 8 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Urban S. Leslie

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fruit West City Mo.

12. MAIDEN NAME OF MOTHER Nellie A. Baker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Co. Idaho.

14. Informant Urban S. Leslie

(Address) ~~Etc~~ Fenn Ida

15. Filed 3 - 3, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to Feb 28, 1930

that I last saw him alive on Feb. 18, 1930

and that death occurred, on the date stated above, at 10:00 m.

The CAUSE OF DEATH* was as follows: Premature Birth Fetus of Gestation about 7½ months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B Chipman, M. D.

3-1-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cottonwood Ida. — Date of Burial: 3-1- 1930

20. Undertaker: Brodbeck Mort Co. — Address: Grangeville Ida.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 29588

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 4

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME ~~Mosar~~ Bessie Beckley

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mosar Andrew Beckley

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Indiana
(State or country)

PARENTS

10. NAME OF FATHER Warren Palmer
11. BIRTHPLACE OF FATHER (city or town) Indiana
(State or Country)
12. MAIDEN NAME OF MOTHER Lillie Grazier
13. BIRTHPLACE OF MOTHER (city or town) Indiana
(State or Country)

14. Informant
(Address) Mosar Andrew Beckley

15. Filed 3-1-30 Grangeville Idaho
Registrar
B Chipman

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to Feb 18, 1930
that I last saw h~~e~~r alive on Feb 18, 1930
and that death occurred, on the date stated above, at 2:00 P m.
The CAUSE OF DEATH* was as follows:
(a) Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coronary Sclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Gen - Chest
What test confirmed diagnosis?
(Signed) B Chipman, M. D.
Feb 19, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	2-20-1930
20. Undertaker	Address
Hawkins Mtg. Co	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

PLACE OF DEATH

County of Idaho

City of Red Rock

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 2181

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69589

Local Registrar's No. 3

74a

2. FULL NAME Julia A Ramond

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) 1852

7. AGE Years 78 Months Feb Days 7 If LESS than 1 day, 7 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) York State

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) France

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canadian

14. Informant G A Heath

(Address) Winona Idaho

15. Filed 3-1-, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-14, 1930, to 2-14, 1930

that I last saw him alive on 2-14-, 1930

and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
4 yrs. a.v.
Myocarditis & Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J P Weber, M. D.

2-14, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Winona Ida. Date of Burial 2-16 1930

20. Undertaker Hancock Mud. Co. Address Grangeville

RECEIVED MAR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69590

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 294

100a

2. FULL NAME Rudolph Harrison Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Smith

6. DATE OF BIRTH (month, day and year): Oct 21 – 18

7. AGE: Years 89 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Brooklyn. N.Y.

PARENTS

10. NAME OF FATHER: Rudolph Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Patterson N.J.
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N.Y.

14. Informant: Bert Smith
(Address): Kooskia – Idaho

15. Filed: March 1, 1930 J M Verbeekmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1, 1930, to Jan 20, 1930
that I last saw him alive on Jan 19, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Arterio sclerosis – Gangrene
right foot – Cystitis (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verbeekmoes, M. D.
Jan 20, 1930 (Address) Kooskia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia Cemetery
Date of Burial: Jan 23 1930

20. Undertaker: Geo. Trenary
Address: Kooskia – Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69591

PLACE OF DEATH
County of Jerome
City of Eden

Registration District No. 33
Primary Registration District No. 3017
(No.)
Local Registrar's No. 1002

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarence Lane Holden
(a) Residence. No. Eden, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Holden

6. DATE OF BIRTH (month, day and year) June 17 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) General farm work
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Indiana ~~Illinois~~

PARENTS

10. NAME OF FATHER Charles W. Holden
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Samantha Jane Lane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Minnie Holden
(Address) 1223-12 St Ringside Calif

15. Filed Mar 10, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 27, 1930
that I last saw h~~is~~ alive on Feb 27, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) S. Hopper, M. D.
, 19 (Address) Hagerman

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls	
20. Undertaker None	Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 – 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69595

Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 1

159e

PLACE OF DEATH
County of Kootenai
City of Harrison
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Crantz
(a) Residence. No. – – – – – – St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1924 - Aug 7

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	5	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Harrison Ida.
(State or country)

PARENTS

10. NAME OF FATHER Axel Crantz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Gladys Vaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Gladys Crantz.
(Address)

15. Filed Mar-1, 1930 H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1930, to Feb. 26, 1930
that I last saw h im alive on Feb. 26, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Insanition
Lower limbs would not support body never assimilate ordinary food – (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Congenital – defective from birth – Mentality – no (duration) yrs. mos. ds.
intelligible sounds knew nobody

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Shryock, M. D.
, 19 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida	3-1 1930
20. Undertaker	Address
Cassedy Funeral Home	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 19 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69595

Dr. H.W. Shryock
Harrison

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Harold Crantz who died at Harrison, Idaho on Feb. 27, 1930
Cause of deathgiven as "Inanition. Congenital--defective from birth."

Information DESIRED in order to complete certificate:

WHAT IS MEANT BY DEFECTIVE FROM BIRTH? MALFORMATION? MENTAL CONDITION?

PLEASE ANSWER BELOW:

Harrison, Idaho Sept 18, 1930

1. Defective from birth. Child could never assimilate ordnary food, As I remember it subsisted on milk and cocoa, no solids.
2. Lower limbs would not support weight of body.
3. no mentality. No intelligible sounds. Did not know even his parents.

Yours truly,

H. W. Shryock

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No.) 44

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69596

Local Registrar's No. 24

2. FULL NAME Fred Schroeder

(a) Residence. No. French Gulch St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. 8 mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schroeder

6. DATE OF BIRTH (month, day and year) June 10, 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	7	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Fred Schroeder

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Louise Schroeder

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Anna Schroeder

(Address) Coeur D' Alene, Idaho

15. Filed 2-21, 1930 N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Feb 18, 1930

that I last saw him alive on Jan 15, 1930

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of the stomach and liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 1-30

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Jno Bentley, M. D.

Feb 19, 1930 (Address) Spokane Wn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	2-20 1930

20. Undertaker	Address
T. B. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1950

(No.) 74a

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69597

Local Registrar's No. 25

2. FULL NAME Margaret E. Forbes

(a) Residence. No. 712 - S. 11th St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Robert M. Forbes.

6. DATE OF BIRTH (month, day and year) 1850 Dec 2 - 7

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	0	7	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Toronto
(State or country) Canada

PARENTS

10. NAME OF FATHER Edward Croker

11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14. Informant Margaret M. Forbes

(Address)

15. Filed 2-28, 1930 A. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1930, to Feb. 14, 1930

that I last saw h~~er~~ alive on Feb. 13 1930

and that death occurred, on the date stated above, at 10 00 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Allwood, M. D.

Feb 15, 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D'Alene	2-17 1930

20. Undertaker Cassedy Funeral Home Address C D'Alene

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69598

Local Registrar's No. 26

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1D 50

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

97

2. FULL NAME Olive Angela Fritts - Lathrom

(a) Residence. No. 1119 - 8th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Walter Lathrom

6. DATE OF BIRTH (month, day and year) 1895 - 11 - 11

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	2	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Roane Co. Tenn

PARENTS

10. NAME OF FATHER Thos. Horace Fritts

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Della Gage

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant O. A. Fritts,

(Address) Coeur d'Alene, Ida.

15. Filed 2-28, 1930 H. J. Sturgess, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec.~~ Jan 31, 1930 to Feb 3, 1930

that I last saw h~~e~~r alive on Feb 3, 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis

not due to pregnancy or childbirth

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Davis, M. D.

Feb 5, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD'Alene	19

20. Undertaker	Address
Cassedy Funeral Home	CD'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 8 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69598

Dr. J.C. Dwyer
Coeur D'Alene, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

- -

In reference to the death certificate of:
Olive Angela Fritts-Lathrom who died at Coeur D'Alene, Ida. on Feb. 3, 1930
Cause of death given as "Thrombosis"

Information DESIRED in order to complete certificate:

WAS THIS CONDITION ASSOCIATED WITH PREGNANCY OR CHILDBIRTH? No.

PLEASE ANSWER BELOW:

No.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69599

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 27

101a

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ronnie Lee Harding

(a) Residence. No. 1215 Mullan St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 18, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	3	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Ida

PARENTS

10. NAME OF FATHER Leslie Harding

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn

12. MAIDEN NAME OF MOTHER Effie Bright

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant Leslie Harding
(Address) Coeur d'Alene Ida

15. Filed 3/7, 1930. H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-10-, 1930, to 2-11-, 1930

that I last saw her alive on 2-10-, 1930

and that death occurred, on the date stated above, at 7,30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. H. Feed, M. D.

2-12, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Forest Cemetery — Date of Burial 2-13 1930

20. Undertaker R. B. Mooney — Address Cd'a Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

123
RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69600

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 28.

(No. 304)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Frank Miller

(a) Residence. (Usual place of abode) No. 818 Front St.
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Johanna Miller

6. DATE OF BIRTH (month, day and year) 1858 - 6 - 1

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work lumber grader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rutledge Timber Co.

9. BIRTHPLACE (city or town) (State or country) Madison Wis.

PARENTS

10. NAME OF FATHER John Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know.
12. MAIDEN NAME OF MOTHER Margaret Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know.

14. Informant Frank C. Miller
(Address)

15. Filed 3/7 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see deceased after death 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 9 00 a. m.

The CAUSE OF DEATH* was as follows:
Sudden death. Probably heart disease not seen by physician prior to death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? -

(Signed) J. E. Brown, M. D.
Feb. 12, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'D'Alene	2-13 1930
20. Undertaker	Address
Cassidy Funeral Home	C'D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69601

PLACE OF DEATH
County of Kootenay
City of Hayden Lake
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 29

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME James Buchan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of:
6. DATE OF BIRTH (month, day and year): May 5 Sept. 3
7. AGE: Years 75 | Months 7 | Days 18 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Canada.

PARENTS
10. NAME OF FATHER: John Buchan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Jean Arnot
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: M. A. Buchan
(Address): Palo Alto Calif.

15. Filed 3/7 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Feb. 21, 1930, that I last saw h~~im~~ alive on Feb 21, 1930, and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Old Age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home. Hayden Lake.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical signs
(Signed) E. E. Sparks M. D.
Feb- 27, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDAlene	2-24 1930
20. Undertaker: Cossedy Funeral Home	Address: CDAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 10 1930

ST OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 60602

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 30
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME William Wells

(a) Residence. No. 1029 - 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1921 - June - 1

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	8	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garfield Bay Idaho

PARENTS

10. NAME OF FATHER Frank Wells
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Geo.
12. MAIDEN NAME OF MOTHER Chlora Barkley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Buckeye Mich.

14. Informant Frank Wells
(Address)

15. Filed 3/7, 1930. W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 22. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 22, 1930
that I last saw him alive on Feb 22, 1930
and that death occurred, on the date stated above, at 10 00 P m.
The CAUSE OF DEATH* was as follows:
Empyema.

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Lobar pneumonia
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? at his home
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinical signs
(Signed) E L Brown M. D.
Feb 26, 1930 (Address) Coeur d'Alene Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'dAlene	2-26 1930
20. Undertaker	Address
Cassedy Funeral Home	C'dAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69602

PLACE OF DEATH
County of Kootenai
City of Coeur d'

Registration District No. 30
Primary Registration District No. 1050
(No. 90)
Local Registrar's No. 31

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maria Travis

(a) Residence. No. 1401 - Walnut St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of W. K. Travis

6. DATE OF BIRTH (month, day and year) 1855-12-28

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Fond du Lac Wis

PARENTS

10. NAME OF FATHER Henry Ogran

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New England

12. MAIDEN NAME OF MOTHER Julia Graham

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. York

14. Informant Mrs. J. S. Hard
(Address) Sand Point, Ida

15. Filed 3/7 1930 H. J. Sturgeon, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 - 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-8-, 1930, to 2-16-, 1930
that I last saw her alive on 2-15-, 1930
and that death occurred, on the date stated above, at 12 00 9. m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis + Chronic heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. A. Teed, M. D.
2-17-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	2-18 1930
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69604

PLACE OF DEATH
County of Kootenai
City of Coeur d' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 32

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Luella Anna Thompson

(a) Residence. No. 1209 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1914 - 8 - 30

7. AGE	Years	Months	Days	If LESS than 1 day,
	15	6	5	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student -
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Bernidga
(State or country) Minn.

10. NAME OF FATHER John Thompson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER Anna Hegg.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Sweden

(PARENTS)

14. Informant John Thompson
(Address)

15. Filed 3/7, 1930 W. J. Sturgeo.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 29, to Mar. 6, 1930
that I last saw her alive on Mar. 5 1930
and that death occurred, on the date stated above, at 2:15 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) John A. Wood, M. D.
Mar. 7, 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. CdAlene	3-7 1930
20. Undertaker	Address
Casedy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69605

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 050

(No. Reed Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

101a

2. FULL NAME Fred Mossburgh

(a) Residence. No. Cougar Gulch St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX White

4. COLOR OR RACE Male

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Leonora Mossburgh deceased

6. DATE OF BIRTH (month, day and year) Dec 12 - 1865

7. AGE Years 65 Months 2 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Former

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Philipp Mossburgh

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) [illegible]

14. Informant Leslie M Mossburgh
(Address) Coeur d'Alene Ida R-D

15. Filed 3/7, 1930 H. J. Sturges. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to Mch 7, 1930

that I last saw him alive on Mch 6, 1930

and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J C Brown, M.D.

Mch 7, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery — Date of Burial 3/9 1930

20. Undertaker N. B. Mooney — Address Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69606

Registration District No.
Primary Registration District No.
Local Registrar's No. 34

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marguerite I Leinum

(a) Residence. No. 416 Mill St.
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William N. Leinum

6. DATE OF BIRTH (month, day and year) Nov 15, 1900

7. AGE	Years	Months	Days	If LESS than 1 day,
	29	3	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER John E Marshall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER Eva Beak
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant William Leinum
(Address) Coeur d'Alene Idaho

15. Filed 3/7, 1930. N J Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 5, 1930
that I last saw h er alive on March 4, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr. Myocarditis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Harold J Sturgis, M. D.
3-6, 1930 (Address) Cda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	March 7 1930
20. Undertaker	Address
C B Mooney	Coeur d'Alene

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69608

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 36
(No. Coeur d'Alene Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Bedford 34

(a) Residence. No. Post Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of anna Bedford

6. DATE OF BIRTH (month, day and year) June 3 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	55	9	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fruit Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs anna Bedford
(Address) Coeur d'Alene Ida.

15. Filed 3/7, 1930 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13-, 1930, to March 3, 1930
that I last saw h[illegible] alive on March 2-, 1930
and that death occurred, on the date stated above, at 9.31 P. m.
The CAUSE OF DEATH* was as follows:

Probably cerebro. spinal fever.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Mc Guire, Ida.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Alexander Jardine, M. D.
3-5-, 1930 (Address) Coeur d'Alene.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	March 6 1930

20. Undertaker	Address
V. V. Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69609

PLACE OF DEATH
County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

48 B

2. FULL NAME Bessie Elizabeth Gentry

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of C.J. Gentry

6 DATE OF BIRTH (month, day and year) Aug. 15, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	27	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Garber Mo.

PARENTS
10 NAME OF FATHER Rufus May
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.
12 MAIDEN NAME OF MOTHER Carrie Snell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Mrs. Carrie May
(Address) Troy, Ida.

15 Filed Feb 28, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Feb. 10, 1930,
that I last saw her alive on Feb. 10, 1930,
and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Thos. A. Meyer M. D.
Feb. 10 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	2/12/30
20. Undertaker H. R. Short	Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6961 0

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Illi

(a) Residence. No. 119 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1-16-1930

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		27	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Troy

PARENTS
10 NAME OF FATHER Geo Benjamin
11 BIRTHPLACE OF FATHER (city or town) (State or country) not known
12 MAIDEN NAME OF MOTHER Rosy Illi
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Fred Illi Father of girl
(Address) Troy Ida

15 Filed Feb 28, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 13 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to Feb. 13, 1930, that I last saw her alive on Feb. 8, 1930, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:
Acute dysentery
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Premature birth.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. A. Meyer M. D.
Feb 13 1930. (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: At Illi Home — Date of Burial: Feb 14 1930
20. Undertaker: None — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69612

PLACE OF DEATH

County of Latah
City of Moscow

CERTIFICATE OF DEATH

Registration District No. 61
Primary Registration District No. 1011
(No. Orchard Ave.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 90

90

2. FULL NAME Seba Ann Passmore

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W.B. Passmore

6 DATE OF BIRTH (month, day and year): May 10, 1865

7 AGE: Years 64, Months 9, Days 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Indianapolis Ind.

PARENTS
10 NAME OF FATHER: Henry J/ Aldridge
11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known
12 MAIDEN NAME OF MOTHER: Susanna Arbuckle
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: W.B. Passmore
(Address): Moscow, Ida.

15 Filed 3/3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. 19, 1930 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to Feby 10, 1930
that I last saw her alive on Feby 10th, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows: Cardio-Vascular Disease
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Cerebral Thrombosis
(duration) ..... yrs. ..... mos. 35 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] Nagee, M. D.
2/20, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 2/21/30 19

20. Undertaker: F. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69613

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 67
Primary Registration District No. 1011
(No.)
Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Laura L. Hall

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James E. Hall

6 DATE OF BIRTH (month, day and year) Aug. 16, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Haywood county N.C.

PARENTS
10 NAME OF FATHER Andy Murry
11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.
12 MAIDEN NAME OF MOTHER Culpatrick
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant U.P. Hall
(Address) Moscow, Idaho

15 Filed 3/3 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 7, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to Feb 7, 1930, that I last saw her alive on Feb. 5, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Acute myocarditis
Chronic Nephritis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
2/10 19 30 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Genesee, Ida.	2/10/30 19
20. Undertaker F.R. Short	Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6961 4

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Latah
Registration District No. 67
City of Moscow
Primary Registration District No. 1011
(No.)
Local Registrar's No. 7
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Gabriel Gibson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elida Gibson

6 DATE OF BIRTH (month, day and year) March 1, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lawerence County Mo.

PARENTS
10 NAME OF FATHER James Gibson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky.
12 MAIDEN NAME OF MOTHER Sarah Ann Boucher
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ten.

14 Informant Mrs. Elida Gibson
(Address) Moscow, Idaho

15 Filed 3/3, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 4, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930 to Feb 4, 1930
that I last saw him alive on Feb 4, 1930
and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Traumatic Fracture base of brain
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Knocked down by auto striking head.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
2/6 1930 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Pullman, Wash.	2/6/30
20. Undertaker	Address
F. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 13 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69614

Dr. C.L. Gritman
Moscow

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

John Gabriel Gibson whodied at Moscow, Idaho on Feb. 4, 1930
Cause of death given as "Traumatic Fracture base of brain."

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE [redacted] PRIMARY CAUSE OF DEATH?

PLEASE ANSWER BELOW:

Was knocked down by an automobile, his head striking the pavement.

Respectfully
Chas. L. Gritman M.D.

Moscow, Idaho.
Sept. 11, 1930

Chas. L. Gritman, M. D.

RECEIVED MAR 5 - 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69615

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 5

2. **FULL NAME** Emma Laura Higgins

(a) Residence. No. St. Pullman Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. 4 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of V. L. Higgins

6 DATE OF BIRTH (month, day and year) Jan 3 - 1868

7 AGE: Years 62 Months — Days 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jasper Mo.

PARENTS

10 NAME OF FATHER James M. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Amanda M S Carthey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Illinois

14 Informant V. L. Higgins

(Address) Pullman Wash.

15 Filed 3/3/30, 19 Have Enhoud Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feby (Month) 1 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1929, to Feb 1, 1930, that I last saw her alive on Feby 1, 1930, and that death occurred, on the date stated above, at 9:00 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. Gutman M. D.

2-1- 1930 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pullman Wash

Date of Burial: Feb 3 1930

20. Undertaker: Kimball & Son

Address: Pullman Wash.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6961 6

PLACE OF DEATH

County of Latah
City of Julietta
Registration District No. 63
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

146

2. **FULL NAME** Alice Lillian Johns

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Arthur W. Johns

6 DATE OF BIRTH (month, day and year) May 19 - 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	8	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Julietta Ida.

PARENTS

10 NAME OF FATHER Duane Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Kansas~~ Kans

12 MAIDEN NAME OF MOTHER Annie L. Leland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Neb.

14 Informant Arthur W. Johns
(Address) Julietta Ida.

15 Filed Feb 10, 1930 B. F. Neafus
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to Feb 10, 1930.
that I last saw her alive on Feb 10, 1930.
and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
puerperal sepsis

(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) pneumonia Influenza - wife before birth
(duration) yrs. 2 wks mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Field M. D.
Feb. 10, 1930 (Address) Kendrick

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Juliaetta	Feb 12 1930
20. Undertaker	Address
None	—

N. B.—Every item of information should be carefully supplied. AGE should be stated WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANEN
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
CUPATION is very important. See instructions on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69617

PLACE OF DEATH
County of Latah
City of Julietta

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sidney A. Hammond

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6. DATE OF BIRTH (month, day and year): Oct 31 1850

7. AGE — Years: 79 | Months: 3 | Days: 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Joseph Hammond
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs John Kite
(Address) Kendrick, Ida.

15. Filed Jan 7, 1930 B. H. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Dec.~~ Jan (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Dec 5, 1929, that I last saw him alive on Dec 5, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Cardio sclerosis
many years
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) chronic nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Field, M. D.
Dec. 7, 1929 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow, Ida. — Date of Burial: Jan 6 1930
20. Undertaker: J. J. Packard — Address: Troy, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69621

PLACE OF DEATH
County of Lemhi
City of Tendoy

Registration District No. 41
Primary Registration District No. 2116
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Clara Melissa Pyeatt
(a) Residence. No. Tendoy Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Frank W. Pyeatt
6. DATE OF BIRTH (month, day and year): Nov 30th 1896.
7. AGE: Years 34 Months 2 Days 15 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Grantsville, Utah
PARENTS
10. NAME OF FATHER: Benjamin F. Marsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Calif.
12. MAIDEN NAME OF MOTHER: Viola S. DeSpain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Toole Utah
14. Informant: Emma I. Gamble
(Address): Salmon Idaho
15. Filed Mar 13, 1930 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 14th 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3 - 0 m.
The CAUSE OF DEATH* was as follows:
This party was dead when I arrived at her home probably Cerebral hemorrhage as gave history high blood pressure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Dont Know
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) T B Wright M. D.
Feby 19th, 1930 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 2-18" 1930
20. Undertaker: Wm C Doebler
Address: Salmon, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69622

PLACE OF DEATH

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

72

2. FULL NAME James F. Inglis

(a) Residence. No. Salmon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: not known

6. DATE OF BIRTH (month, day and year): 9/28/74

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
55	6	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mining Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): not employed at time

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: not known James L. Inglis

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England not known

12. MAIDEN NAME OF MOTHER: not known Harriet Inglis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): not known England

14. Informant: Ralph Irvin Ralph Irvin
(Address) Salmon, Idaho.

15. Filed Mar 13, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24, 1930, to March 9, 1930 that I last saw him alive on 10:20 PM Mar 9, 1930 and that death occurred, on the date stated above, at 10-20 P.m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis

(duration) 4th 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Syphilis

(duration) several years yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Wassermann

(Signed) F S Wright, M. D.

Mar 10, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City — Date of Burial: 3-16th 1930

20. Undertaker: Wm C Doebler — Address: Salmon Idaho

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69623

PLACE OF DEATH
County of Lemhi
City of Salmon Ida.
Registration District No. 1
Primary Registration District No. 2116
Local Registrar's No.
(No.) 100a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Barney Monahan
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work County Farm
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Fred Brough Jr.
(Address) Salmon Ida.

15. Filed Mar 13, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 14th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7-35 P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Primary About 2 weeks
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteria sclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hamner, M. D.
March 3, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	2-15th 1930
20. Undertaker	Address
Jno C Jacobs	Salmon, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69624

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

88B

2. FULL NAME Lucretia Barr Simons
(a) Residence. No. Salmon Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Caucasian
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Jan 27 1857

7. AGE 73 Years Months Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portland Ore.

PARENTS
10. NAME OF FATHER James Hill.
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Caroline Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant O. A. Simons
(Address) Salmon Ida

15. Filed Mar 13, 1930 Cho Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Feb 25, 1930
that I last saw her alive on Feb 25, 1930
and that death occurred, on the date stated above, at 12:3 A m.
The CAUSE OF DEATH* was as follows:
Chronic syst carditis
Several months (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
primary (duration) yrs. mos. 22 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) Chas F Hammer, M. D.
March 3, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 2-26th 1930

20. Undertaker Wm. C Doebler
Address Salmon

RECEIVED MAR 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69625

PLACE OF DEATH
County of Lemhi
City of Salmon Ida

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Rosa Ellen Harrison 45
(a) Residence. No. Salmon Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lee Harrison

6. DATE OF BIRTH (month, day and year)

7. AGE Years 64 Months 7 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Terre Haute Ind

PARENTS
10. NAME OF FATHER Phil. Jordan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Terre Haute Ind.
12. MAIDEN NAME OF MOTHER Nancy Parker Coffman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Terre Haute Ind

14. Informant Ray Harrison
(Address) Salmon Ida.

15. Filed Mar. 13, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1, 1930, to Feby 28, 1930
that I last saw her alive on Feby 27th, 1930
and that death occurred, on the date stated above, at 7-30 P m.
The CAUSE OF DEATH* was as follows:
Cancer of lower Colon
(duration) Dnt Know yrs. mos. ds.
CONTRIBUTORY (Secondary) Dnt Know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dnt Know
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? T B Wright M. D.
(Signed) March 1st, 1930 (Address) Salmon Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shilbina Mo
Date of Burial 19

20. Undertaker Wm C Doebler
Address Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6626

PLACE OF DEATH
County of Lemhi
City of Leadore

Registration District No. 41
Primary Registration District No. 2116

Local Registrar's No.

(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Holt

(a) Residence. No. Leadore Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5-1841

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	88	5	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) General Merchant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Edward Holt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Mat Kearns
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs. W.R. Hodgson
(Address) Salmon Idaho

15. Filed 2/11, 1930 Chas. C. Bellam
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 5-30 P m.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Jas C Doebler Coroner M. D.
2/8, 1930 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Salmon Cemetery — Date of Burial: 2-10th 1930

20. Undertaker: Jas C Doebler — Address: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69627

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

74a

2. FULL NAME Alberta Grace Anders

(a) Residence. No. Carmen Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William H. Anders

6. DATE OF BIRTH (month, day and year) Nov 19 - 1886

7. AGE: 43 Years | Months: 2 | Days: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmers Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bozeman Montana

PARENTS

10. NAME OF FATHER: William F. McDonald
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oskaloosa Iowa
12. MAIDEN NAME OF MOTHER: Flora J. Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Prairie City Illinois

14. Informant W H Anders
(Address) Carmen Idaho

15. Filed Feb 11, 1930 Curt C Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 6th, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 6, 1930
that I last saw her alive on Feb 6, 1930
and that death occurred, on the date stated above, at 6-40 P m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
indeterminate (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hanne, M. D.
2/13, 1930 (Address) Hanne

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 2-8" 1930

20. Undertaker: J M C Doeckler | Address: Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69628

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

41

2. FULL NAME Roland Franklin Sullivan
(a) Residence. No. Salmon 2 yrs. 6 mo. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Sullivan.

6. DATE OF BIRTH (month, day and year)

7. AGE: 42 Years | Months: 1 | Days: 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: teamster
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Morrison Illinois.

PARENTS
10. NAME OF FATHER: James Franklin Sullivan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Orville Ohio
12. MAIDEN NAME OF MOTHER: Miss Ardella Marsh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ashland Ohio

14. Informant: Mrs Ira Gable
(Address) Salmon Idaho

15. Filed Feb 11, 1930 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 4" (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1929, to Nov. 12, 1929
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 12.20 P.m.
The CAUSE OF DEATH* was as follows: Sepsis from foci of infection in teeth & tonsils
..... (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Angina pectoris; death took place before my arrival
..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) ..... M. D.
2/6, 1930. (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gibbonsville Ida | Date of Burial: 2-6" 1930

20. Undertaker: Wm C Daehle | Address: Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69629

PLACE OF DEATH
County of Lemhi
City of Carmen

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

48 B

2. FULL NAME Emma Caroline McCracken
(a) Residence. No. Carmen, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 35 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank P. McCracken

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 71, Months 5, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lisbon, Iowa

PARENTS
10. NAME OF FATHER: John Long
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Nancy Kelsey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: W. E. McCracken
(Address): Carmen, Idaho

15. Filed Feb. 11, 1930 Clio C Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 P.M. ~~Jan~~ February (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Jan, 1930
that I last saw her alive on Jan 1, 1930
and that death occurred, on the date stated above, at 8 P.M. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
no 3 year (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) General debility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
2/13, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 2-5-30

20. Undertaker: Wm C Doebler
Address: Salmon Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69630

PLACE OF DEATH

County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. At home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME James Thomas Spencer

(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Christena Marie Spencer

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 69 | Months 5 mo. | Days 12 da. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lankshire England
(State or country)

PARENTS

10. NAME OF FATHER James Thomas Spencer
11. BIRTHPLACE OF FATHER (city or town) ? England
(State or Country)
12. MAIDEN NAME OF MOTHER Mary - ?
13. BIRTHPLACE OF MOTHER (city or town) England
(State or Country)

14. Informant Mrs Spencer
(Address) Salmon Ida

15. Filed Feb 11, 1930 Chas Bellamy
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2-1 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1928, to Feb 1, 1930
that I last saw him alive on Feb 1, 1930
and that death occurred, on the date stated above, at 1-35 P m.
The CAUSE OF DEATH* was as follows:
Aortic regurgitation

(duration) several months yrs. mos. ds.

CONTRIBUTORY (Secondary) Leco motor ataxia
about 1 year (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer M. D.
2/13, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 2-4" 1930

20. Undertaker: McC Doebler | Address: Salmon Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69633

PLACE OF DEATH

County of Lemhi

City of Salmon

Registration District No. 4

Primary Registration District No. 2116

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME Roy Esper Gott

(a) Residence. No. Shoup St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Gott

6. DATE OF BIRTH (month, day and year) 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	9		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Candy Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lowell Mass. Kent County

PARENTS

10. NAME OF FATHER Frank

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Twin Falls

12. MAIDEN NAME OF MOTHER Carlie Whitero

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant Mrs Roy E. Gott

(Address) Rt Salmon Ida

15. Filed Feb 11, 1930 Clint C Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to Feb 10, 1930, that I last saw him alive on Feb 10, 1930, and that death occurred, on the date stated above, at 12:25 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Colon

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F.S. Wright, M. D.

Feb 11, 1930 (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	1930
20. Undertaker Wm C Dobler	Address Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69634

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 56
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

89 B

2. FULL NAME Isaac Thompson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6. DATE OF BIRTH (month, day and year) Dec 21 1848

7. AGE Years 81 Months 1 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant H E Simmons
(Address) Craigmont Ida

15. Filed 7/28, 1930 R E Dewelfe Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to Feb 20, 1930
that I last saw him alive on Feb 20, 1930
and that death occurred, on the date stated above, at 12:30 a m.
The CAUSE OF DEATH* was as follows:
Chr. myocarditis.
Auricular Fibrillation
Arterio Sclerosis - Hypertrophy of Prostate
..... (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Lab & Physical Exams
(Signed) Ralph M. Alley, M. D.
Feb 20, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal I O O F Cemetery Craigmont, Ida — Date of Burial 2-22 1930

20. Undertaker Craigmont Hdwe Co — Address Craigmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 5 – 1930

PLACE OF DEATH

County of Lewis

City of Winchester

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 229

(No. Winchester Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69635

Local Registrar's No. 2

F3 1

2. FULL NAME Mc Bride Clark

(a) Residence. No. Winchester Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lilly M. Clark

6. DATE OF BIRTH (month, day and year) Oct 30 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	2	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer, Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Lu Clark

(Address) Winchester, Ida.

15. Filed 1/31, 1930 P. A. Duncan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930 to Jan 19, 1930

that I last saw h[illegible] alive on Jan 19, 1930

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cystitis -
Hypertrophied Prostate

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. & Lab.

(Signed) Ralph M. Alley, M. D.

Jan 20, 1930 (Address) Winchester

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Golden Ridge Cemetery Winchester Ida — Date of Burial: Jan 21 1930

20. Undertaker: C. E. Clovis — Address: Craigmont Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 5 - 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69636

County of Lewis

City of Craigmont R.F.D. Registration District No. 60

Primary Registration District No. 2129

Local Registrar's No. 1

48B

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Buttrey

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | 4. COLOR OR RACE White | 5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Clara Maude Buttrey

6. DATE OF BIRTH (month, day and year) Aug 1 1869

7. AGE: Years 60 | Months 5 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER William J. Buttrey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Virinda Jout

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Orval Wilford Buttrey
(Address) Craigmont Idaho

15. Filed Jan 17, 1930. R. E. Dunlap Registrar
per H. W. Shryock

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan. 14, 1930
that I last saw him alive on Jan. 14, 1930
and that death occurred, on the date stated above, at 9:00 A.m.
The CAUSE OF DEATH* was as follows:

Weakness following influenza,
Myocarditis
1 (duration) ~~2 yrs.~~ 7 months + mos. + ds.

CONTRIBUTORY (Secondary) Influenza weakness
follows (duration) 2 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Shryock, M. D.

Jan 17, 1930 (Address) Craigmont.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Craigmont.	Jan. 18 1930
20. Undertaker C. E. Clovis	Address Craigmont.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69637

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 14

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME John Johanson

(a) Residence. No. Rexburg St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male.	white	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marion (Larson) Johanson

6. DATE OF BIRTH (month, day and year) May 16 1834

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
95	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER John Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Anna Knutson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Joseph Johanson
(Address) Rexburg, Idaho

15. Filed 3/5 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Mar. 4, 1930
that I last saw him alive on Mar 4, 1930
and that death occurred, on the date stated above, at 6:30 A. m.
The CAUSE OF DEATH* was as follows:-
General debility due to old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) M Sutherland, M. D.
3-5, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Edwood Cemetery Idaho	Mar 7 1930
20. Undertaker	Address
T W Eckersell	Rigby

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...tem of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...hould state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69638

County of Rexburg
City of Madison

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

44

2. FULL NAME Allen Siglin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada K Eakew Siglin

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 54, Months 1, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Taxi Service
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Mona Iowa

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs Ada Siglin
(Address) Rexburg Idaho,

15. Filed 3/4, 1930 J Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to Feb 27, 1930
that I last saw him alive on Feb 27, 1930
and that death occurred, on the date stated above, at 11:00 a m.
The CAUSE OF DEATH* was as follows: Carcinoma Pyloric end stomach
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Ulcer stomach
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Feb. 21
Was there an autopsy? No
What test confirmed diagnosis? Metastasis
(Signed) H B Rigby, M. D.
Feb. 28, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City Cemetary
Date of Burial: Mar 1st 1930

20. Undertaker: Vern J Keller
Address: Rexburg,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69639

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

148 e

2. FULL NAME Fredric Merle Fisher

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lucinda (Tolman) Fisher

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 43 | Months | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bountiful Utah

PARENTS

10. NAME OF FATHER: John Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Harriett Knighton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: John J. Fisher
(Address) Hooper Utah R.F.D. 2

15. Filed 3/4, 1930 J. Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 24 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1930, to Feb. 24, 1930
that I last saw him alive on Feb. 24, 1930
and that death occurred, on the date stated above, at 1:00 a m.
The CAUSE OF DEATH* was as follows:
Automobile Collision accident.
Broken neck (Fractured cervical spine)
Fractured skull.
Concussion & laceration of brain
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H B Rigby, M. D.
Feb. 26, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bountiful Cemetary | Date of Burial: 3/2 1930

20. Undertaker: C. B. Eckersell | Address: Rigby

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69640

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 278
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

124

2. FULL NAME Bluford Leroy Bybee.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ester Bybee

6. DATE OF BIRTH (month, day and year) June 30 1893

7. AGE: 36 Years | Months 7 | Days 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fairview Utah.

PARENTS

10. NAME OF FATHER: Absolan A Bybee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah.
12. MAIDEN NAME OF MOTHER: M Elizebeth Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St George Utah

14. Informant: Mrs Elizebeth Bybee
(Address): Thornton Idaho Route# 1.

15. Filed 3/4, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to Feb. 17, 1930
that I last saw him alive on Feb. 17, 1930
and that death occurred, on the date stated above, at 1:15 P. m.
The CAUSE OF DEATH* was as follows:
Acute Peritonitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Acute appendicitis
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 2/14/30
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A. Butterfield M. D.
2-19, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lyman Cemetary.	Feb 20th 1930
20. Undertaker: Vern J Keller.	Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MAR 8 1930

DO NOT WRITE IN THIS SPACE
State File No. 6964

PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 278
Local Registrar's No. 10
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Constance Lazilla McKenna. 17

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: X

6. DATE OF BIRTH (month, day and year): July 8 1906.

7. AGE: Years 22. Months 6 Days 28. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home.
(b) General nature of industry, business, or establishment in which employed (or employer): " School.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hibbard Idaho.

PARENTS:
10. NAME OF FATHER: Thomas McKenna.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland.
12. MAIDEN NAME OF MOTHER: Rebeca Hendricks.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah.

14. Informant: Rebecca McKenna.
(Address): Rexburg Idaho.

15. Filed 3/4, 1930 J Rigby Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to 2 6, 1930
that I last saw her alive on Feb 5, 1930
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H R Rigby M. D.
Mar 4, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Cem.	Feb 10 1930
20. Undertaker	Address
Vern J Keller.	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. 856 5-25 M. 1-1 MAR 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 53643

Local Registrar's No. 6

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Wesley Craven

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Boy	White	Child

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1929 (Year)

7. AGE: Yrs. 11 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rupert Idaho

10. NAME OF Father: Emmett N. Craven

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ola M. Clevenger

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmett N Craven
(Address) Rupert. Idaho

15. Filed 3-9 1930 Ed T Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26 1930, to Feb. 23 1930, that I last saw him alive on Feb. 22 1930, and that death occurred on the date stated above, at 2-20 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... yrs. 1 mos. ..... ds.
Contributory (Secondary) Tonsillitis
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Ed T Elmore M. D.
3-9 1930 (Address) Rupert. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert. Idaho — DATE OF BURIAL: 2-25 1930

20. UNDERTAKER: Wm Goodman — ADDRESS: Rupert. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69644

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. ....)
Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Billie Joy Hall

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 22, 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	3	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Rupert

PARENTS

10. NAME OF FATHER David W Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Gwen Whiting
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant W. W. Hall
(Address) Rupert Ida

15. Filed 3-8-30 E V Johnson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 6, 1930
that I last saw he alive on Mar 6, 1930
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(duration) .... yrs. .... mos. 4 ds.
CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? Rupert
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Fayne A. Kenyon, M. D.
Mar 8 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Ida	Mar. 8. 1930

20. Undertaker D. E. Johnson — Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAR 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69645

Local Registrar's No. 4

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Lou Oldham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Fe	White	Single

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1929 (Year)

7. AGE: Yrs. 3 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minidoka Idaho

10. NAME OF Father: Jesse L. Oldham

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Elsie Prince

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jesse L. Oldham
(Address): Rupert. Ida

15. Filed 3 — 6 1930 E. O. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16

16. DATE OF DEATH: March (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3 1930, to Mar. 3 1930, that I last saw her alive on March 3 1930, and that death occurred on the date stated above, at 6 30 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... yrs. 3 mos. 22 ds.

Contributory (Secondary): Improper feeding

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Elmore M. D.

3-6 1930 (Address) Rupert. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert - Ida. DATE OF BURIAL: 3 - 5 1930

20. UNDERTAKER: Moore ADDRESS:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69646

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 17
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

117

2. FULL NAME Cleone Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16, 1924

7. AGE Years 5 Months 6 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER James O Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Amelia Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Marion Utah.

14. Informant J. O. Peterson
(Address) Rupert Ida

15. Filed 2-17, 1930 C H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 15, 1930
that I last saw her alive on Feb 14, 19..
and that death occurred, on the date stated above, at 2:10 a. m.
The CAUSE OF DEATH* was as follows:
Appendicitis - ruptured

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) peritonitis

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? Rupert
Did an operation precede death? yes Date of Feb 10
Was there an autopsy? no
What test confirmed diagnosis? operation
(Signed) Fayre H. Kinsey, M. D.
2-17, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial Feb 17 1930

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6647

PLACE OF DEATH
County of Minidoka
City of Paul
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

24

2. FULL NAME Jean Revol Munson

(a) Residence. No. Paul St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Girl	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Munson

6 DATE OF BIRTH (month, day and year) May 11 1928

7 AGE one Years ~~eleven~~ Months Days Seventeen
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Paul
(State or country)

PARENTS

10 NAME OF FATHER John D. Munson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lehester Utah.

12 MAIDEN NAME OF MOTHER Sarah Winn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lemmit Utah.

14 Informant John D. Munson
(Address) Paul. Idaho

15 Filed 3-6, 1930 Ed Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 1 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to March 1, 1930, that I last saw her alive on Feb. 28, 1930, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:
Cerebro-Spinal meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Spinal fluid

(Signed) Ed Elmore M. D.

3-6, 1930 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Paul. Ida.	March 2 1930
20. Undertaker none	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69648

PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME James Power

(a) Residence. No. St. Lapwai Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 75 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: L B Hamm

(Address) Lewiston Idaho

15. Filed Feb, 1930 George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eric Brower Coroner, M.D.

2/13, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spalding Idaho

Date of Burial: 2/13 1930

20. Undertaker: Brower-Hamm

Address: Lewiston Idaho

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69649

PLACE OF DEATH

County of Nez Perce

City of Lapwai

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100 a

2. FULL NAME Virginia Williams

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/10/1928

7. AGE 1 Years | Months 1 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lapwai Idaho.

PARENTS

10. NAME OF FATHER George Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nespelem, Wash.

12. MAIDEN NAME OF MOTHER Martha Stevens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lapwai Idaho.

14. Informant Martha Williams
(Address) Lapwai, Idaho

15. Filed Feb, 1930 George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 22nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-18-, 1930, to 2-22-, 1930

that I last saw her alive on 2-21-, 1930

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Gaignard, M. D.

2/22-, 1930 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lapwai, Idaho. | Date of Burial: 2/24 1930

20. Undertaker: Brower-Wenn Co | Address: Lewiston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 26 M. 1-12. MAR 13 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69650

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. St.)

2. FULL NAME Mrs Nellie Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 81 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Jp mah ta ya Depots

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abel Grant
(Address) Lapwai Idaho.

15. Filed Feb 1930 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16- 1930, to 2-20 1930, that I last saw h[illegible] alive on 2-20 1930, and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

2/20/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69651

PLACE OF DEATH
County of Nez Perce
City of Culdesac

Registration District No. 128
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Theodore Mattson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Mattson

6. DATE OF BIRTH (month, day and year): Jan 8 1870

7. AGE: Years 60 | Months — | Days 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Otter County Minne

PARENTS

10. NAME OF FATHER: Nels. J. Mattson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Engrid Lindberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs. T. Mattson
(Address) Culdesac - Idaho

15. Filed Feb, 1930. George Gaignard
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Crushed Chest + Side accidental. Crushed by Wag on against Post. Killed (duration) Monthly yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Em Brower Coun, M. D.
2/4, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: 2/5 1930

20. Undertaker: Brower-Warne Co | Address: Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAR 13 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69652

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

2. FULL NAME William Reed Flint

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH Sept (Month) 12 (Day) 1850 (Year)

7. AGE 79 Yrs. 4 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Androscoggin Maine

10. NAME OF Father Alden Flint

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Marcia Weston

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alden Flint

(Address) Culdesac Idaho.

15.

Filed Feb 1930 George Gaymard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH Jan (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, **to** Jan 29 1930, **that I last saw him alive on** Jan 29 1930, **and that death occurred on the date stated above, at** 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 11 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaymard M. D.

Feb 1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Idaho. **DATE OF BURIAL** Feb 2 1930

20. UNDERTAKER Nasser Undertaking Co. **ADDRESS** Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69653

PLACE OF DEATH
County of Nezperce
City of Culdesac
Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Anna Eliza Conger

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harold Conger

6. DATE OF BIRTH (month, day and year) Oct. 25, 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	3	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fayettville Arkansas

PARENTS

10. NAME OF FATHER (?) Brandon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Elizabeth Bricxy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant James Morrow (Son)
(Address) Ferdinand, Ida.

15. Filed Jan- 1930 George Gaymard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-2- 1929, to 8-9 1929
that I last saw h- alive on 8-9 1929
and that death occurred, on the date stated above, at 11:00 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaymard M. D.
Jan. 27. 1930 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Culdesac Ida	1/29/30 19

20. Undertaker H.R.Merchant — Address Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69654

PLACE OF DEATH

County of Nez Perce
City of Culdesac

Registration District No. 128
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

88B

2. FULL NAME Mahala Lanning Peer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lavega Peer

6. DATE OF BIRTH (month, day and year): 1848

7. AGE: 82 Years | Months: 3 | Days: 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Columbus Ohio

PARENTS

10. NAME OF FATHER: William English
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Leigh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Sherman Peer
(Address): Culdesac Idaho

15. Filed Jan, 1930 George Gaignard MD Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Jan 12, 1930
that I last saw her alive on Jan 6, 1930
and that death occurred, on the date stated above, at 3:15 A. m.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis
(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
1/12/30, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: LeClede Mo. | Date of Burial: 19

20. Undertaker: Merchant | Address: Clarkston Wn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-30 RECEIVED MAR 13 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 128

State File No. 69655

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho.

If death occurs away from usual residence, give facts called for under special information.

Primary Registration District No. (No. Culdesac & Vicinity St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Osman Keck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH Sept (Month) 15 (Day) 1875 (Year)

7. AGE 54 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Physician & Surgeon

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Greenville Pennsylvania

10. NAME OF Father George Osman Keck

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Louise Allison

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs George O. Keck

(Address) Lapwai Idaho.

15. Filed Jan 20 1930 George Gaignard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw him alive on Jan 11 — 1930,

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Ruptured Aneurysm of the arch of the Aorta Died Suddenly

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

1/11/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston, Idaho

DATE OF BURIAL Jan. 15. 1930

20. UNDERTAKER Brower-Wann

ADDRESS Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

PLACE OF DEATH

County of Nez Perce

City of Lapwai

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 128

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69656

Local Registrar's No.

101a

2. FULL NAME Charles A. Wing

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Tillie Wing

6. DATE OF BIRTH (month, day and year) 12/7/87

7. AGE Years 58 Months Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER W. W. Wing

11. BIRTHPLACE OF FATHER (city or town) (State or Country) No

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant

(Address)

15. Filed Feb, 1930 George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan. 8, 1930 that I last saw him alive on Jan. 8, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. O. Kelly Per Dr. G.G. M. D.

Dr. Kelly, 1930 (Address)

Dr. Kelly died before certificate was made. George Gaignard M.D. Registrar

State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho

Date of Burial 1/11 1930

20. Undertaker Brower-Wann Co.

Address Lewiston Idaho

FORM V. S. No. 5-25 M. 1-19

REC'D MAR 13 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69657

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac & Vicinity St.)

2. FULL NAME William Henry Gage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

6. DATE OF BIRTH: October (Month) 1 (Day) 1857 (Year)

7. AGE: 72 Yrs. 3 Mos. 6 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Gardner, Illinois

10. NAME OF Father Thomas W. Gage

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Martha Rogers

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Gage
(Address) Craig Idaho.

15. Filed Jan. 1930 George Gagnaux Local Registrar

MEDICAL CERTIFICATE OF DEATH 10 1a

16. DATE OF DEATH: Jan (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-30-1929, to Jan 6- 1930, that I last saw him alive on Jan-6- 1930, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....yrs. ....mos. 8 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) George Gagnaux M. D.

1/6/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston, Idaho. DATE OF BURIAL Jan 7 1930

20. UNDERTAKER Vassar Undertaking Co. ADDRESS Lewiston Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69658

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

168

2. FULL NAME Ephraim Monson
(a) Residence. No. Malad Rt 1 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May-21-1870

7. AGE: Years 59 | Months 9 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hyrum Ut.

PARENTS

10. NAME OF FATHER: Andrew Monson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Matilda Petersen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Max Monson
(Address) Malad Idaho

15. Filed 2/28, 1930 J. W. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Coroners jury Verdict:
"Died by his own hand"
(hanging)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Jas R. Davis (Coroner) D
Feb. 26, 1930 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John Ida | Date of Burial: Feb. 26 1930

20. Undertaker: J. Guy Benson | Address: Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69659

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No.
Primary Registration District No.
Local Registrar's No. 11
(No. 114)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Leon Hughes
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 19, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho

PARENTS

10. NAME OF FATHER Walter J. Hughes
11. BIRTHPLACE OF FATHER (city or town) Pleasant View
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Merle Daniels
13. BIRTHPLACE OF MOTHER (city or town) Malad
(State or Country) Idaho

14. Informant Walter J. Hughes
(Address) Malad Ida

15. Filed 3/24, 1930 J. M. Nevins Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 22, 1930
that I last saw h[illegible] alive on Feb 22, 1930
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows: Acute Enteritis.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Nevins M. D.
3/24, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	Feb. 24 1930
20. Undertaker	Address
J. Guy Benson	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69660

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.) Local Registrar's No. 10
(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Reed Tundell
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 14 1905
7. AGE Years 24 Months 11 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Woodruff Ida.

PARENTS
10. NAME OF FATHER Isaac David Tundell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Willard Utah.
12. MAIDEN NAME OF MOTHER Julia Bell Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cresent Iowa

14. Informant O L Tundell
(Address) Malad Ida
15. Filed 2/28, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 31, 1928 to Feb. 20, 1930
that I last saw him alive on Jan. 15, 1930
and that death occurred, on the date stated above, at 7.30 A. m.
The CAUSE OF DEATH* was as follows:
Fracture of 6 & 7 cervical vertebrae resulting in total paralysis of arms & below. (duration) 1 yrs. 6 mos. 20 ds.
CONTRIBUTORY (Secondary) Bed sores & gradual weakening. (duration) living from 12 ft yrs. mos. ds.
18. Where was disease contracted if not at place of death? stand at swimming pool slipped & struck head
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) V. P. Garst, M. D.
Feby 21, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial Feb. 23 1930
20. Undertaker J. Guy Benson
Address Malad Ida

RECEIVED SEP 10 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69660

Dr. V.P. Garst
Malad

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Reed Zundell who died at Malad, Idaho on Feb. 20, 1930
Cause of death given as "Fracture of 6 and 7 vertebrae resulting in total paralysis of arms and below."

INFORMATION DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE XXXXXX PRIMARY CAUSE OF DEATH.

PLEASE ANSWER BELOW:

Diving from stand 12 ft. high at Ady swimming resort. Slipped and dove too near the bank striking ground with head.

V. P. Garst, M.D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69661

PLACE OF DEATH
County of Oneida
City of Malad.

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10

2. FULL NAME Floral Talbot
(a) Residence. No. Malad Rt 1 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 14. 1923

7. AGE Years 6 Months 9 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Groveland Idaho

PARENTS
10. NAME OF FATHER Cash Talbot
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemington Utah
12. MAIDEN NAME OF MOTHER Rosalie A. Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rexburg Idaho

14. Informant Andie Talbot
(Address) St John

15. Filed 2/28, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 15 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930 to Feb 15, 1930
that I last saw her alive on Feb 15, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Diphtheria

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
2/16, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John Ida. Date of Burial Feb. 16 1930

20. Undertaker J. Guy Benson Address Malad Ida

RECEIVED MAR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69662

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 8
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Coleen Draper
(a) Residence. No. ..... St. 7
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 17 - 1928

7. AGE Years 1 Months 1 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Oda

PARENTS
10. NAME OF FATHER Carl S. Draper
11. BIRTHPLACE OF FATHER (city or town) Moroni
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Udan Christopherson
13. BIRTHPLACE OF MOTHER (city or town) Logan
(State or Country) Ut.

14. Informant .....
(Address) Roy Christopherson Malad Oda

15. Filed 2/28, 1930 J. M. Harris
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930 to 4 hours, 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 11:20 am.
The CAUSE OF DEATH* was as follows:
Measles
Cause doubtful
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W. H. Mabey M. D.
2/3, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Logan Utah
Date of Burial Feb 4 1930

20. Undertaker J. Guy Benson
Address Malad Oda

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69663

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 23

PLACE OF DEATH

County of Owyhee
City of Marsing
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wellington Andrew Mc Kague

(a) Residence. No. Homedale Ida R#1 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30-1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	5	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Isac Mc Kague

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Sarah Orr

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Julia Prince
(Address) Marsing Idaho.

15. Filed 2-24-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1929, to Dec. 2, 1929
that I last saw him alive on Dec 21, 1929
and that death occurred, on the date stated above, at 3 A. m.
The CAUSE OF DEATH* was as follows: Carcinoma Stomach

(duration) yrs. 6-12 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & X Ray
(Signed) S B Dudley, M. D.
Feb 20, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Feb-20 1930
20. Undertaker	Address
C. J. Peckham	Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69664

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 51
Primary Registration District No. 2130
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

74a

2. FULL NAME Elroy E Nokes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 7, 1859

7. AGE Years 70 Months 2 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Daniel Nokes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Samathy Percy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Earl Nokes
(Address) Fruitland Ida

15. Filed Jan 9, 1930 Mrs Wm T. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Jan 7, 1930
that I last saw him alive on Jan 7, 1930
and that death occurred, on the date stated above, at 3 p. m.
The CAUSE OF DEATH* was as follows:
Apoplexy –

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J R Woodward, M. D.
Jan 9, 1930 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal N. Plymouth Ida — Date of Burial Jan 9 1930

20. Undertaker W. H. Adair — Address Peterson Furn Co Payette

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69665

PLACE OF DEATH

County of Payette

City of New Plymouth

Registration District No. 5

Primary Registration District No. 2009

Local Registrar's No. 2

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Prior

90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 1854

7. AGE Years 76 Months Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eng.

PARENTS

10. NAME OF FATHER Alfred Prior

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eng.

12. MAIDEN NAME OF MOTHER Rebecca Dean

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Eng

14. Informant Harry C Prior

(Address) New Plymouth

15. Filed Feb 8, 1930 Wm T. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1930 (Year)

viewed the remains after death.

17. I HEREBY CERTIFY, That I attended deceased from Jan 21, 1929, to Feb 6, 1930

that I last saw him alive on Nov 14, 1929

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

..... (duration) many yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis

..... (duration) many yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Presumably in Ohio.

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical evidence

(Signed) Wm T. Drysdale, M. D.

Feb 8, 1930 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New Plymouth

Date of Burial Feb 9 1930

20. Undertaker J. H. Adair Address Peterson Furn Co Payette Ida

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69666

PLACE OF DEATH
County of ~~Bear Lake~~ Payette
City of ~~..~~ Plymouth
Registration District No. 5
Primary Registration District No. 2009
Local Registrar's No. 1
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth L Hurtle 97

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Da Hurtle

6. DATE OF BIRTH (month, day and year) April 31-1853

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Jno Sloan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Jane Hester
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant W. G. Hurtle
(Address) Lodi Calif

15. Filed Jan 26, 1930. Wm J. Dryspale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 24, 1930
that I last saw h[illegible] alive on Jan 26, 1930
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:

Embolism of femoral artery

..... (duration) ..... yrs. ..... mos. 3 hours ds.

CONTRIBUTORY (Secondary) Influenza with pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? clinical evidence
(Signed) Wm J. Dryspale, M. D.
Jan 26, 1930 (Address) Plymouth.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Plymouth	Jan 26 1930

20. Undertaker J. Hagan Address
Peterson Furn Co Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69667

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Power

City of Am Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

(No. .....)

Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

48 R

2. FULL NAME Alonza Sturm

(a) Residence. No. Co Poor Home St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): March 3rd 1841

7 AGE: Years 88 | Months 11 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ills

PARENTS

10 NAME OF FATHER: not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Ras Sturms AWD

(Address) American Falls, Idaho

15 Filed 2-14, 1930 Genevieve Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 13th (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb 10, 1930, that I last saw him alive on Feb 10, 1930, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows: Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

2-14, 1930 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I.O.O.F Cem.

Date of Burial: 2/14/30

20. Undertaker: AW Davis, AM Falls

Address

RECEIVED MAR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69668

PLACE OF DEATH

County of Power

City of Rockland

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

(No. .....)

Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

.44a

2. FULL NAME Ellie Adore Harris

(a) Residence. No. Rockland Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Anna Peterson

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 64 | Months 11 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10 NAME OF FATHER: Joseph Mormon Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Windoul Luzerne Penn.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Ezra Harris

(Address) Tremonton Utah

15 Filed Feb 12, 1930 Genevieve Nolte Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 9 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1930, to Feb 8, 1930, that I last saw ~~him~~ alive on Feb 7 1930, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arthritis Deformans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Feb. 12, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rockland, Idaho

Date of Burial: 2-12 1930

20. Undertaker: Family

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69669

PLACE OF DEATH
County of Shoshone
City of Constitution Mine

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 17

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

186

2. FULL NAME John C Schubert

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Schubert

6. DATE OF BIRTH (month, day and year) Jan 9, 1900

7. AGE Years 30 Months 1 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER John F. Shubert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Emma Ditzel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Carl Shubert
(Address) Kellogg Idaho

15. Filed Feb. 28, 1930. Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 11 30 a m.
The CAUSE OF DEATH was as follows: Body & Head badly broken up by fall down shaft in Constitution Mine (duration) ..... yrs. ..... mos. ..... ds. Instant
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H C Mowery Coroner, M.D.
2/25, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida — Date of Burial Feb. 26 1930

20. Undertaker M. C. Thornhill — Address Kellogg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

179111 N

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69670

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

206

2. FULL NAME Baby Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 23. 30

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg
(State or country)

PARENTS

10. NAME OF FATHER Ward Williams
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Nellie Hinckerhood
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Ward Williams
(Address) Kellogg Idaho

15. Filed Feb. 28, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH Lindsay

16. DATE OF DEATH Feb 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23rd, 1930, to ....., 19....
that I last saw h..... alive on Still Born, 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Unknown unless influenza on part of mother 10 days previous
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. C. Lindsay, M. D.
2/24, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Idaho
Date of Burial Feb 25 1930

20. Undertaker M. C. Thornhill
Address Kellogg Idaho

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69671

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 15

(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Schonewald

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 18, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			1	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Ida.
(State or country)

PARENTS

10. NAME OF FATHER Tim Schonewald
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Edna G. Myott
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Tim Schonewald
(Address) Kellogg, Ida.

15. Filed Feb. 28, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH Lindsay

16. DATE OF DEATH Feb 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 19, 1930, to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Prematurity.
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. L. Lindsay, M. D.
2/24, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg, Idaho	Feb 20, 1930
20. Undertaker	**Address**
M. C. Thornhill	Kellogg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69672

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 14

(No. 179)

PLACE OF DEATH

County of Shoshone

City of Kellogg

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Charles Boxter

(a) Residence. No. 103 W. Mullan St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 19 - 1913

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	16	3	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: High School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moscow Ida

PARENTS

10. NAME OF FATHER Joseph Boxter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Moscow.

12. MAIDEN NAME OF MOTHER Ruth McCrossin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Joe Boxter

(Address)

15. Filed Feb. 19, 1930. Mrs. Helen McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 18, 1930

that I last saw him alive on Feb 18, 1930

and that death occurred, on the date stated above, at 12:59 P. m.

The CAUSE OF DEATH* was as follows:

accident - 2+3rd degree burns of over one half the body due to explosion of gasoline while repairing a car

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. T. Kennett, M. D.

Feb. 18, 1929 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida.	Feb 21 1930

20. Undertaker: O. L. Stout — Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE... MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69673

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 13

(No. ...)

(If death occurred in a hospital or institution, give its name instead of street and number.)

119

PLACE OF DEATH

County of Shoshone

City of Kellogg

2. FULL NAME Raymond Eugene Pruitt

(a) Residence. No. ... St. ...
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 30, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	4	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9. BIRTHPLACE (city or town) Kellogg, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Fred Pruitt

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Amelia Nearing

13. BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country) B. Columbia

14. Informant Fred Pruitt
(Address) Kellogg Idaho

15. Filed Feb. 28, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feb 2, 1930, to Feb 5, 1930
that I last saw him alive on Feb 5, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Intussusceptin of bowel

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? ...

(Signed) J. R. Hussan M. D.
2/8, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	2/7/1930

20. Undertaker	Address
M. P. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 6674

Local Registrar's No. 12

1000a

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2207

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry B. Pope

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Martha Pope

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	67			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Miner

(c) Name of employer .....

9. BIRTHPLACE (city or town) ~~Wales~~ England
(State or country)

PARENTS

10. NAME OF FATHER no info

11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)

12. MAIDEN NAME OF MOTHER no info.

13. BIRTHPLACE OF MOTHER (city or town) England
(State or Country)

14. Informant M. P. Thornhill

(Address) Kellogg, Idaho

15. Filed Feb. 28, 1930 Mrs. Helen M. Bridges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Feb. 3, 1930.

that I last saw him alive on Feb. 3, 1930

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) T. W. Lansaw, M. D.

2-4, 1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillsboro, Oregon	Feb 6, 1930

20. Undertaker	Address
M. P. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 89675

PLACE OF DEATH
County of Shoshone
City of Kellogg, Idaho

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Fresina Frankino

(a) Residence. No. Kellogg Idaho — St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) — — 1849

7. AGE

Years	Months	Days	If LESS than 1 day
81	—	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER Antonio Frankino
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Nonify
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant William Frank
(Address) Kellogg Idaho

15. Filed Feb. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 6th, 1930 to Feb 9th, 1930
that I last saw her alive on Jan 26, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Myocarditis & old age.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms.
(Signed) W. C. Lindsay, M. D.
2/12, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Feb 12 1930

20. Undertaker	Address
M. S. Thornhill	Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 7 1930

PLACE OF DEATH

County of Shoshone

City of Kellogg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. 2201

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69676

Local Registrar's No. 10

186

2. FULL NAME Joel A. Krohn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 2, 1890

7. AGE: Years 39, Months 9, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B. H. & S. Co.

9. BIRTHPLACE (city or town) (State or country): Montana

PARENTS

10. NAME OF FATHER: John Krohn

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Frances Schultz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. W. L. Merrill

(Address) Sequim - Wash.

15. Filed Feb. 28, 1930. Mrs. Helen McBride, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows: Crushed to death by mask.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): None Instant

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [signature] Mowery Coroner

1/30, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho — Date of Burial: 2/2 1930

20. Undertaker: M. C. Thornhill — Address: Kellogg, Idaho

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69677

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 9

(No. 127 St.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME E. M. Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Don't know

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) — — —

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	—	—	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work millman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) no info

PARENTS

10. NAME OF FATHER no info

11. BIRTHPLACE OF FATHER (city or town) (State or Country) no info

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) no info

14. Informant M. J. Bottinelli
(Address) Kellogg Idaho

15. Filed Feb 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 10, 1929, to Jany 19, 1930
that I last saw him alive on Jany 19, 1930
and that death occurred, on the date stated above, at 4 A m.
The CAUSE OF DEATH* was as follows:
Cirrhosis Liver
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of .....
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) J. R. Wilson, M. D.
1/31, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Jan 31, 1930
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69678

PLACE OF DEATH
County of Teton
City of Tetonia

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

48B

2. FULL NAME Verda Miner
(a) Residence. No. Tetonia St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 3, 1913

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
16	2	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho

PARENTS

10. NAME OF FATHER A. C. Miner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fairview Utah
12. MAIDEN NAME OF MOTHER Mattie Robins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scipio Utah

14. Informant A. C. Miner
(Address) Tetonia, Id.

15. Filed 2-18-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1930, to Jan. 27, 1930
that I last saw her alive on Jan 27 1930
and that death occurred, on the date stated above, at 11 15 P.m.
The CAUSE OF DEATH* was as follows:
Myocarditis (acute acetbaton)
Bronchitis
Infantile Paralysis 11 yrs duration
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Deformity of chest
from Paralysis (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) H. B. Rigby, M. D.
Feb 13, 1931 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Tetonia
Date of Burial: Feb 9 1930

20. Undertaker: C. E. Harris
Address: Tetonia
Acting

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69679

PLACE OF DEATH

County of Teton

City of Driggs

Registration District No. 77

Primary Registration District No. 2176

Local Registrar's No. 2

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Amanda Ferguson Price 74a

(a) Residence. No. Driggs, Ida. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 8th 1850

7. AGE: 79 Years | Months: 4 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Louis Mo.

PARENTS

10. NAME OF FATHER Geo. Washington Price

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgetown Pa.

12. MAIDEN NAME OF MOTHER Elizabeth M. ~~H. Price~~ Ferguson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Glasgow Scotland

14. Informant L. P. Griggs
(Address) Driggs, Idaho

15. Filed 2-17-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 14th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Feb. 14, 1930, that I last saw her alive on Feb. 10, 1930 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Senile Arterio-sclerosis

..... (duration) several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Major Mortis

(Signed) L. T. Tadner, M. D.

2/15, 1930 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Driggs Cemetery | Date of Burial: Feb. 16th 1930

20. Undertaker: — | Address: —

RECEIVED MAR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6968 6

PLACE OF DEATH
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 3917
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Oliver Phelps 4

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23-1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	4	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burke, Ida

PARENTS

10. NAME OF FATHER Howard Phelps
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mont Kans
12. MAIDEN NAME OF MOTHER Ruth Briggs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Sam Briggs
(Address) Burke Ida

15. Filed Feb. 11, 1930 J. T. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to Feb. 11, 1930
that I last saw him alive on Feb. 11, 1930
and that death occurred, on the date stated above, at 2:20 A m.
The CAUSE OF DEATH* was as follows:
Scarlet fever
(duration) yrs. mos. 2 3 ds.
CONTRIBUTORY (Secondary) Gastro-Intestinal
hemorrhage (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? + blood in stool
(Signed) A. A. Morrison, M. D.
Feb 11, 1930 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Ida	2/13 1930

20. Undertaker	Address
L. Johnson	Burke Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAR 7 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2-687
File No. 69681
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls Co (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. Gen'l Hospital

2. FULL NAME Katie Fair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr. (Month) 6th (Day) 1888 (Year)

7. AGE: 41 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payson, Utah

10. NAME OF FATHER: Richard N. Gough

11. BIRTHPLACE OF FATHER (State or Country): Provo, Utah,

12. MAIDEN NAME OF MOTHER: Martha Ellen Steward

13. BIRTHPLACE OF MOTHER (State or Country): Payson, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ray Fair
(Address) Burke.

15. Filed Feb. 11 1930 — J. N. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

41

16. DATE OF DEATH: Feb (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-Feb- 1930, to 9-Feb 1930, that I last saw her alive on 9-Feb- 1930, and that death occurred on the date stated above, at 9.25 A.M.

The CAUSE OF DEATH* was as follows:

Septicaemia
abortion - Self inflicted

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Anemia - [redacted]

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. W. MacManus M. D.

Feb 11 1930 (Address) Burke, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: 2/12 1930

20. UNDERTAKER: L. Johnson — ADDRESS: Burke Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69682

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

133

2. FULL NAME A. J. Flowers

(a) Residence. No. St. Dr. Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 14

7. AGE: 94 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS
10. NAME OF FATHER: Flower.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): —
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: J. B. Drake
(Address): Twin Falls

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 28 1930 (Month) (Day) (Year) 8-15

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Feb. 28, 1930
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 8:15 a. m.
The CAUSE OF DEATH* was as follows:
~~Senile~~ Cystitis
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
3/1, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Mar 1 1930

20. Undertaker: F. C. Drake | Address: Twin Falls

RECEIVED SEP 8 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

69681

Dr. F.W. MacManus
Buhl

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Katie Fair who died at Twin Falls, Idaho on Feb. 9, 1930
Cause of death given as "Septicemia"

Information DESIRED in order to complete certificate:

WAS THIS CONDITION ASSOCIATED WITH PREGNANCY OR CHILDBIRTH? Abortion, self-inflicted

PLEASE ANSWER BELOW:

I think I know some of the medicine she obtained from a neighboring town.

F.W. MacManus

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69683

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 154

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mildred League

(a) Residence. No. Kimberly RFD #1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	single

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 30 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	2	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida.

PARENTS

10. NAME OF FATHER Ralph League
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kans.
12. MAIDEN NAME OF MOTHER Edith Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant
(Address)

15. Filed 3-6-, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/13, 1930, to 2/25, 1930
that I last saw h[illegible] alive on 2/25, 1930
and that death occurred, on the date stated above, at 6:30 a. m.
The CAUSE OF DEATH* was as follows:
General Peritonitis of Streptococcus origin—
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Respiratory
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of 2/23/30
Was there an autopsy? no
What test confirmed diagnosis? clinical & operative
(Signed) J. M. Davis, M. D.
2/25, 1930 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls	
20. Undertaker	Address
J. J. Grossman	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69684

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

111B

2. FULL NAME S. J. Wideberg

(a) Residence. No. 502 54 Ave West St. Dr. Coughlin

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 1885

7. AGE Years 44 Months 4 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mcanic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Wideberg

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mpman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs. Addie L. Wideberg

(Address) Twin Falls

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-19, 1930, to 2-23, 1930

that I last saw him alive on 2-23 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage from duodenal ulcer

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Coughlin M. D.

2-25, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Ida

Date of Burial 19

20. Undertaker T. E. Drake

Address

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69685

PLACE OF DEATH
County of Twin Falls
City of Berger

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101 (B)

2. FULL NAME Helen Dorothy Idol
(a) Residence. No. Berger St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 1/1925
7. AGE Years 4 Months 3 Days 1B If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER H T Idol
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Grace Cavaras
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Georgia

14. Informant H T Idol
(Address) Berger

15. Filed 3-6-, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 23 1930
(Month) (Day) (Year)

17. ~~I HEREBY~~ CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 23, 1930
that I last saw her alive on Feb 23, 1930
and that death occurred, on the date stated above, at 4.30 m.
The CAUSE OF DEATH* was as follows:
Croupous pneumonia.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Glanchik, M. D.
Feb 23, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Feb 25 1930
20. Undertaker T C Drake
Address T Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69686

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.) County Hospital

2. FULL NAME H. G. Brock
(a) Residence. No. Filer St. Dwight
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 28/1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	1	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Jas Brock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Sally Hollenbeck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Mrs H. G. Brock
(Address) Filer Idaho

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Feb. 22, 1930
that I last saw him alive on Feb. 22, 1930
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows:

Septicaemia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Streptococcic Infection following mastoid.
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Filer Ida.
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Laboratory
(Signed) F. A. Dwight, M. D.
Feb. 23, 1930 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moberly Mo	Feb 1930
20. Undertaker	Address
F. E. Drake	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69687

PLACE OF DEATH
County Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME Elenor Mary Hoehn

(a) Residence. No. 177 Quincy St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11 1921

7. AGE Years 8 Months 8 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Andrew Hoehn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Clara Sheldon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant Andrew Hoehn
(Address) Twin Falls

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to 2-21, 1930
that I last saw her alive on 2-21, 1930
and that death occurred, on the date stated above, at 9:30 P m.
The CAUSE OF DEATH* was as follows: Bronchio Pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John Coughlin M. D.
2-25, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Feb 24 1930

20. Undertaker F. E. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69688

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Feraled Mullins
(a) Residence. No. Twin Falls Ida - 2 mi S.W. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 28-1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16	10	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mrs. A. J. Green

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. A. J. Green
(Address) Twin Falls Idaho

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to Feb. 21, 1930
that I last saw him alive on Feb. 19, 1930
and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis, cerebro-spinal.
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not determined.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical & laboratory findings.

(Signed) W. T. Rosser, M. D.
Feb 21, 1930 (Address) Twin Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Twin Falls Ida	2-21 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls. Ida.

SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Leave nothing uncertain. ATTENTION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69689

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No.
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ethel Allen

(a) Residence. No. Filer St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 12 1914

7 AGE	Years	Months	Days	If LESS than 1 day, or hrs. min.
	15	8	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10 NAME OF FATHER L D Allen
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio
12 MAIDEN NAME OF MOTHER Bernice Cutler
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colo

14 Informant L D Allen
(Address) Filer

15 Filed 3-6-, 1930 Elizabeth G. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 15 (Day) 30 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1930, to Feb. 15, 1930, that I last saw her alive on Feb. 15, 1930, and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. A. Newbern M. D.
Feb. 15, 1930. (Address) Filer Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Twin Falls | Date of Burial Feb 16 1930

20. Undertaker [illegible] | Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69692

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

Weaver 47 B

2. FULL NAME Cornelious N. Griffith

(a) Residence. No. 4 mi South Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 24 - 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	71	1	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10. NAME OF FATHER J. E. Griffith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Mary Carr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alabama

14. Informant J A Griffith
(Address) Twin Falls Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to Feb. 13, 1930
that I last saw him alive on Feb. 13, 1930
and that death occurred, on the date stated above, at 11:30 A.m.
The CAUSE OF DEATH* was as follows:
Myocarditis
General (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
2/13, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	Feb 15 1930
20. Undertaker	**Address**
White Mortuary Inc.	Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

PLACE OF DEATH

County of Twin Falls

City of " "

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69693

Registration District No.

Primary Registration District No. Local Registrar's No.

(No. Cor Fee Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Mrs Minnie Tatman

(a) Residence. No. Visalia Calif. St. Visalia Calif.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 7 1884

7. AGE: Years 45 Months 2 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10. NAME OF FATHER: Joseph Phillips

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Elizabeth Pond

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant

(Address)

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb-13 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-1, 1930, to Feb-13, 1930

that I last saw her alive on Feb-13, 1930

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Septicaemia

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 1/31/30

Was there an autopsy? yes

What test confirmed diagnosis? Operation + clinical

(Signed) J M Davis, M. D.

2/14, 1930 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Madison Kansas

Date of Burial 19

20. Undertaker: P. J. Grossman

Address: Twin Falls

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69694

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Le Roy Fike
(a) Residence. No. Hansen St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 6/30

7. AGE Years — Months — Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER H L Fike
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Ida Nicks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant H L Fike
(Address) Hansen

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 12 1930 7:00
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on 2/6, 1930, to ——, 19
that I last saw him alive on 2/6, 1930
and that death occurred, on the date stated above, at 7:30 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
2/13, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls — Date of Burial Feb 13 1930

20. Undertaker F E Drake — Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 9695

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. .....

PLACE OF DEATH

County of Twin Falls.

City of Twin Falls

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Glenn Edward Noble

(a) Residence. No. 182 N. Washington St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1013

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Alveda Noble

6. DATE OF BIRTH (month, day and year) Jan 30 - 1905

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	0	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Construction

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Twin Falls Highway Co.

9. BIRTHPLACE (city or town) (State or country) Okla

PARENTS

10. NAME OF FATHER Edward H. Noble

11. BIRTHPLACE OF FATHER (city or town) (State or Country) [illegible]

12. MAIDEN NAME OF MOTHER Clara Lois Benscoter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. C. W. Parks

(Address) 643 - Main E.

15. Filed 3-6-, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 - , 1930, to Feb 10, 1930

that I last saw him alive on Feb. 10, 1930

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia + Infec. Throat a case

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Sign or Symp. Laboratory

(Signed) John R. Morgan, M. D.

Feb. 10 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~ or Removal	Date of Burial
Twin Falls Ida.	2-11 1930

20. Undertaker White Mortuary — Address Twin Falls Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69696

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

120

2. FULL NAME Nora B. Tish
(a) Residence. No. Twin Falls, Route #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Ambrose W. Tish

6. DATE OF BIRTH (month, day and year) Aug 22-1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	5	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt Vernon South Dakota

PARENTS

10. NAME OF FATHER Fred Griene

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary E Chantry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Ambrose W. Tish
(Address) Twin Falls, Ida Route #1

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to Feb 5, 1930, that I last saw her alive on Feb 5th, 1930 and that death occurred, on the date stated above, at 4 40 a.m.

The CAUSE OF DEATH* was as follows:
Acute Yellow atrophy of Liver
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Chr Cholecystolethiasis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 2-4-30
Was there an autopsy? yes
What test confirmed diagnosis? Sig Appearance & Lesions & microscopic
(Signed) C. Russell Hesler M. D.
2-7, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	2-8 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69697

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
(No.) Local Registrar's No. 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sia Owens
(a) Residence. No. 330 Blue Lake Blvd St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 11 1850
7. AGE: 79 Years | 5 Months | 7 Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Clay Missouri

PARENTS
10. NAME OF FATHER Horace Owens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Polly Lane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Owens
(Address) Twin Falls
15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 3 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 3, 1930, that I last saw h[illegible] alive on Feb 2 1930, and that death occurred, on the date stated above, at 3A m.
The CAUSE OF DEATH* was as follows:
Complete Arterio-sclerosis
Senile dement
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W Coughlin M. D.
2-[illegible], 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Feb 7 1930
20. Undertaker: [illegible] Lake | Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69698

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

2. FULL NAME C W Metcalf
(a) Residence. No. 145 Washington St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. Dr Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 26 1875

7. AGE Years 54 Months 2 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Anthony Melcalf
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jose E. Dawford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs C. W. Melcalf
(Address) Twin Falls

15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4th, 1930, to Feb 3d, 1930
that I last saw him alive on Feb 3d, 1930
and that death occurred, on the date stated above, at 7-25 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H E Lamb, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gunnison Utah
Date of Burial 19

20. Undertaker T C Duke
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69699

PLACE OF DEATH

County of Twin Falls

City of Filer

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Katie Miller

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of L. A. Miller

6. DATE OF BIRTH (month, day and year) March 25 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	10	7	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Ch Home

(c) Name of employer

9. BIRTHPLACE (city or town) Indiana
(State or country)

PARENTS

10. NAME OF FATHER Hawke Hygema

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Holland

12. MAIDEN NAME OF MOTHER Fetke Riecebraw.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Holland.

14. Informant Mrs A Osborn
(Address) Filer Ida

15. Filed 3-6, 1930 Elizabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to Feb 1, 1930
that I last saw h alive on Jan 20, 1930
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H W Goucher, M. D.

Feb 1, 1930, (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Ida	Feb 3 1930
20. Undertaker L. J. Johnson	Address Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69700

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

24

2. FULL NAME Mrs. Margaret Fields
(a) Residence. No. 135 6th Ave E St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 20 1871
7. AGE Years 58 Months 5 Days 10 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Chas Harbough
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Fordyce
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Hill
(Address) 135 6 E.
15. Filed 3-6, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1930, to Jan. 30, 1930, that I last saw her alive on Jan. 29, 1930 and that death occurred, on the date stated above, at 6 A m.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis.
(duration) — yrs. — mos. 1 day.
CONTRIBUTORY (Secondary) Influenza.
(duration) — yrs. — mos. 3 ds.
18. Where was disease contracted if not at place of death? Not known.
Did an operation precede death? No. Date of
Was there an autopsy? No. Findings.
What test confirmed diagnosis? Clinical & laboratory
(Signed) M. F. Asser M. D.
Feb. 6, 1930. (Address) Twin Falls Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Ida | Date of Burial Feb 2 1930
20. Undertaker Grossman | Address

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED MAR 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Donnelly

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ..... St.)

File No. 69702

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Axe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married* (Write the word.)

6. DATE OF BIRTH Jan. (Month) 21 (Day) 1[illegible]

7. AGE 68 Yrs. Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER Henry S. Ax

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor W. Ax

(Address)

15. Filed Feby 9 1930 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH Feb. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw & examined body of deceased ~~from~~ 2/8 1930 ~~to~~ at 10.45 P.M. ~~19~~

that I ~~last~~ never saw him alive ~~on~~ 2/8 1930,

and that death occurred on the date stated above, at about 10.20 M.

The CAUSE OF DEATH* was as follows: apparently failure of heart — following an acute attack of tonsillitis or quinzy.

(Duration) ~~Yrs.~~ about ~~mos.~~ 5 ds.

Contributory (Secondary) Articular Rheumatism & Nephritis or Bright's disease.

(Duration) several yrs. ~~mos.~~ ds.

(Signed) Dr. S. Hunter M. D.

19 (Address) McCall Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Finnish Cemetery near Rosebery (Ida) DATE OF BURIAL Feb 13 1930

20. UNDERTAKER. Wm McBrotsky A.S. Robb ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 11 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69703

Registration District No. 15
Primary Registration District No.
Local Registrar's No.

164

PLACE OF DEATH
County of Latah
City of Arling

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Brüta Kantola

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 25- 1843

7. AGE	Years	Months	Days	If LESS than 1 day,
	87			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kalajoki Finland

PARENTS

10. NAME OF FATHER Mike Rahaja

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kalajoki Finland

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Jonpo Kantola
(Address) Arling Idaho

15. Filed Feb 8, 1930 Stella Cain
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Senility
No Physician,
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Friss Cemetery,	Feby 11 1930

20. Undertaker None — Address

FORM V. S. No. 5-A--25 M. 1-19.

RE — MAR 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 15

Primary Registration District No.

File No. 6970 4

County of Valley

City of Cascade (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Bertha Morrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1910 (Year)

7. AGE: 20 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Council Idaho

10. NAME OF FATHER: W B Wooden

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Peebles

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oliver J. Morrison

(Address)

15. Filed Feby 14 1930 Stella Crain Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1930 to Feb 13 1930, that I last saw her alive on Feb 13 1930, and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:

Toxic hyperthyroidism

(Duration) 0 Yrs. 3 mos. 0 ds.

Contributory (Secondary): Pregnancy

(Duration) 0 yrs. 3 mos. 0 ds.

(Signed) Forrest E Ward M. D.

2/14 1930 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: Feby 16 1930

20. UNDERTAKER: Wm McBratney — ADDRESS: Council Ida

FORM V. S. No. 5-A-25 M. RECEIVED MAR 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

File No. 69705

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Ralph Hamerick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1928 (Year)

7. AGE: 1 Yrs. 2 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): McCall Idaho

10. NAME OF FATHER: Frederick R Hamerick

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Ila Coonrod

13. BIRTHPLACE OF MOTHER (State or Country): Van Wyck Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred R. Hamrick

(Address)

15. Filed 2/12 1930 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 11 (Month) (Day) 1930 (Year) 1000

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1930, to Feb. 11 1930 that I last saw him alive on Feb. 11, 1930 and that death occurred on the date stated above, at 11 20 P.M.

The CAUSE OF DEATH* was as follows:

acute - Bronchial Pneumonia

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Lower resistance

(Duration) yrs. 2 mos. ds.

(Signed) Dr U S Scott M. D.

19 (Address) McCall, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall Idaho

DATE OF BURIAL: Feb 13 1930

20. UNDERTAKER: Wm McBratney

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19

RECEIVED MAR 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18

Primary Registration District No.

File No. 69706

Registered No.

1. PLACE OF DEATH

County of Valley

City of 4 Mi from McCall (No., St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas B Youngs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: About 70 Years (Yrs.) (Mos.) (ds.)

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A S Robb Coroner

(Address) Valley County Idaho

15. Filed March 1 1930

Stella Caire
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

From Hemorrhage of the Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A S Robb Coroner M. D.

19..... (Address) Valley County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho | DATE OF BURIAL: Mar 2 1930

20. UNDERTAKER: Wm McBratney | ADDRESS: Cascade Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13 MAR 3 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69707

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marguette A Hare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widdow (Write the word.)

6. DATE OF BIRTH. Feb (Month) 28 (Day) 1857 (Year)

7. AGE 72 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Louis Smith

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) x Julia Hannaman
(Address) A

15. Filed 2-28-30 191 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 5 (Day) 1930 (Year) 440

17. I HEREBY CERTIFY, That I attended deceased from July 6 1928, to July 6 1928, that I last saw her alive on July 6 1928, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis & Asthma

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hurst M. D. ~~M. D.~~

..... 19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida

DATE OF BURIAL 1-7 1930

20. UNDERTAKER [illegible]

ADDRESS Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

1. PLACE OF DEATH MAR 3 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....

Primary Registration District No.....

File No. 69709

County of Washington

City of Cambridge

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Wendy Lord

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 19 (Day) 1899 (Year)

7. AGE: 30 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Wendel

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Ann Beard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) X Chas Wendel
(Address) .....

15. Filed 2-28-30 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 4 (Day) 1930 (Year) 146

17. I HEREBY CERTIFY, That I attended deceased from 12-27-29 191..., to 1-4-30 191..., that I last saw h.. alive on 1-4-30 191..., and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

..... (Duration) 1 Yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. 4 mos. 6 ds.

(Signed) C W Nielsen M. D.

19..... (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Jan 6 1930

20. UNDERTAKER: J A Hedelund — ADDRESS: J A Hedelund

SYMS - YORK CO., PTRS. & BORS. 24654

69710

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69710

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 29

(No. U. S. Vet. Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob Carl HECK

31

(a) Residence. No. Burke, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. J. C. Heck

6. DATE OF BIRTH (month, day and year): 3-17-1879

7. AGE: Years 51, Months 0, Days 3. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Motorman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 3-22, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1926, to March 20, 1930

that I last saw him alive on March 20, 1930

and that death occurred, on the date stated above, at 11:00 A.M. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pul. chr. active far advanced B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculous enteritis; Tuberculous laryngitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX

Did an operation precede death? XX Date of

Was there an autopsy? XX

What test confirmed diagnosis? XX

(Signed) F. C. SMITH, Reg. Med. Officer, M. D.

3-21-30, 19 (Address) U.S. Vet. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery — Date of Burial: 3/22/30 19

20. Undertaker: Wm. McBratney — Address: Boise, Idaho

RECEIVED MAR 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

69711

DO NOT WRITE IN THIS SPACE

State File No. 69711

PLACE OF DEATH

County of Kootenai

City of Rathdrum

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 39

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Oscar L Sheffield

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov. 17-1872

7. AGE: Years 57 | Months 3 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Surveyor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Surveyor of Kootenai County Ida

9. BIRTHPLACE (city or town) (State or country): Duchun Wisconsin

PARENTS

10. NAME OF FATHER: Joseph Sheffield

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pittsburg, Penn.

12. MAIDEN NAME OF MOTHER: Anna E Cloip

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: Clark Sheffield
(Address): Post Falls Idaho

15. Filed 3/24, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1. 1930 to March 2. 1930

that I last saw him alive on March 1. 1930

and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

about (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

about (duration) ..... 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Frank Kramer, M. D.

3/4, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Rest Cemetery - Rathdrum	3/4 1930
20. Undertaker	Address
Caseedy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

69712

RECEIVED MAR 27 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69712

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1 51

2. FULL NAME William Seaward Davis

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Ruth Davis

6. DATE OF BIRTH (month, day and year) Oct 24. 1896

7. AGE Years 33 Months 4 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montepellier Ida

PARENTS
10. NAME OF FATHER David W Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montpellier Ida
12. MAIDEN NAME OF MOTHER Ada May Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pittsburg Penn.

14. Informant David W Davis
(Address) Pocatella Ida

15. Filed 3/11, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5th, 1930, to March 11, 1930
that I last saw him alive on March 11th 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Acute Gangrene
Gall Bladder
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Tonsillitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of March 9th
Was there an autopsy? No
What test confirmed diagnosis? Elevation
(Signed) C. F. Keller, M. D.
3/26, 1930 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome Cemetery
Date of Burial 3-13 1930

20. Undertaker D A L Herisson
Address Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lyle 69713

DO NOT WRITE IN THIS SPACE

State File No. 69713

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. 519—11th St.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

195

PLACE OF DEATH

County of Nez Perce

City of Lewiston

2. FULL NAME Andrew J. Fraary

(a) Residence. No. 519—11th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9/11/1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	3	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Coal miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs A J Fraary

(Address) Lewiston Idaho.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 3rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1927, to Jan 3, 1930, that I last saw him alive on Jan 3, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Lyle, M. D.

1/4, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial 19

20. Undertaker: Brown-Wamboldt — Address: Lewiston Idaho

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69714 (69714)

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 28

(No. 10 1/2 a H.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Vernon Beach

(a) Residence. No. 3 Miles North West of Boise (If nonresident give city or town and State.)

(Usual place of abode.)

Length of residence in city or town where death occured 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 26 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Creamery Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Westford Vermont

PARENTS

10. NAME OF FATHER George Beach

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Sarah C Rice

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mrs Edsel M Grover R No 4, Boise Idaho

15. Filed 3-17 1930 W. N. Rhoades Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 15, 1930

that I last saw him alive on Mar 14, 1930

and that death occurred, on the date stated above, at 5a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Cobar Pneumonia

Lower left lobe

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Gangrene of Lung

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Bradshaw M. D.

Mar 15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Burlington Vermont — Date of Burial: March 27 1930

20. Undertaker: Summers & Kreta — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

69715

DO NOT WRITE IN THIS SPACE

State File No. 69715

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 30

(No. U.S.Vet.Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME John W. SAVIERS

(a) Residence. No. Shoshone, Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. x yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. J. W. Saviers

6. DATE OF BIRTH (month, day and year) 10-10-1844

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	85	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 3-22, 1930 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1929, to Mar. 21, 1930
that I last saw him alive on March. 21, 1930
and that death occurred, on the date stated above, at 2 P.M. m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general
Myocarditis, chr.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx
Did an operation precede death? xx Date of
Was there an autopsy? xx
What test confirmed diagnosis? xx

(Signed) F. C. SMITH, Reg.Med.Officer M. D.
3-22-30, 19 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone, Idaho
Date of Burial: 3/23/30 19

20. Undertaker: Wm.McBratney.
Address: Boise, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69717

69717

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 95
(No. St. Alphonsus Hospital 685)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Martin Subisarreta

(a) Residence. No. ..... St. Mountain Home
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? 9 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11-11-1900

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	29	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheepman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10. NAME OF FATHER Antonio Subisarreta
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Patricia Elorza
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Spain

14. Informant (Address) M. E. [illegible] Mountain Home

15. Filed Apr 2, 1930 W. L. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 21st, 1930, to March 28, 1930
that I last saw him alive on Mch 28, 1930
and that death occurred, on the date stated above, at 4.50 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mastoiditis, acute suppurative Left
(duration) — yrs. — mos. 15 ds.
CONTRIBUTORY (Secondary) otitic Meningitis
(duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? Mountain Home
Did an operation precede death? yes Date of Mch 21/30
Was there an autopsy? no
What test confirmed diagnosis? Spinal Fluid Ex.
(Signed) Cal Cawle, M. D.
Apr 2, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Mountain Home — Date of Burial 3/30 1930

20. Undertaker: Schreiber & McCann — Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED APR 3 1930

69718

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69718

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

196

2. FULL NAME Harry G. Collipriest
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 19 1896

7. AGE Years: 33 Months: 3 Days: 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Line Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Utah Power & Light Co

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: Henry Collipriest
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elsie Gordon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Mrs Henry Collipriest
(Address) Montpelier, Idaho

15. Filed 3/31, 1930 N H Berg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Instantly killed by accidently coming in contact with the cut out on the lifre side of circuit.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) T M Williams, M. D.
Mar 2, 1930 (Address) County Coroner Montpelier, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier Idaho
Date of Burial: Mar. 4 1930

20. Undertaker: T M Williams
Address: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

69719

DO NOT WRITE IN THIS SPACE

State File No. 69719

Registration District No. 123

Primary Registration District No. 3201

Local Registrar's No. 15

1010

PLACE OF DEATH

County of Shoshone

City of Kellogg

(No. Wardner Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Loyd Stone

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Man	White Irish	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Virginia Stone

6. DATE OF BIRTH (month, day and year) Nov 1, 1893

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	4	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mining Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garfield Washington

PARENTS

10. NAME OF FATHER William Stone

11. BIRTHPLACE OF FATHER (city or town) (State or Country) California

12. MAIDEN NAME OF MOTHER Elizabeth Gallagher

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mary Virginia Stone

(Address) Kellogg Idaho

15. Filed Apr. 1, 1930 Mrs. Helen M. Pride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-12, 1930, to 3-16-, 1930

that I last saw him alive on 3-16-, 1930

and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Spokane, Wash.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) F. W. Laraway, M. D.

3-18-, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg, Idaho	Mch 18 1930
20. Undertaker	Address
M. L. Thornhill	Kellogg, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH APR 4 1930

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH 6972-0

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 6972-0

Local Registrar's No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William J. Huggins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

6. DATE OF BIRTH: Oct. 17 (Month) (Day) 1881 (Year)

7. AGE: 48 Yrs. 5 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dentist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF Father: Seymour Huggins

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Browning

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs W. J. Huggins
(Address): Rupert, Idaho

15. Filed March 21 1930 E. O. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1930 (Year) 48

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2 1929, to March 20 1930, that I last saw him alive on March 20 1930, and that death occurred on the date stated above, at 12 05 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary): none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Elmore M. D.

3-21 1930 (Address) E. O. Elmore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Mar. 23 1930

20. UNDERTAKER: Rodney Goodman — ADDRESS: Rupert, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

69721

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69721

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1804
Local Registrar's No. 99
(No. St Alphonsus Hospital, 14
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Franklin Benjamin Long

(a) Residence. No. 1106 1/2 Main St St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 7 1882

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	9	2,	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Squire Long
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Ellen Murray
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant Mrs Alene Guernsey
(Address) Spokane Wash

15. Filed 4-9 1930 W. D. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 31 1930, to April 9 1930
that I last saw him alive on April 1 1930
and that death occurred, on the date stated above, at 10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Spotted Fever

(duration) yrs. mos. 2 1 ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at shop
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) F W Almond M. D.
4-9 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr 11 1930
20. Undertaker: Summers & Krebs — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

69722

DO NOT WRITE IN THIS SPACE
State File No. 69722

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Bro. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5793

117

2. FULL NAME Anna C. Carlson

(a) Residence. No. 437 West Bayden St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John B. Carlson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eureka Utah

PARENTS
10. NAME OF FATHER Henry Cale
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Rosa Steniker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant John B. Carlson
(Address) 437 West Bayden St

15. Filed 3/31, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1930, to Mar 28, 1930
that I last saw her alive on Mar 28, 1930
and that death occurred, on the date stated above, at 1 15-a m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage
following ruptured
appendix
(duration) — yrs. — mos. 6 ds.
CONTRIBUTORY (Secondary) Ruptured
appendix (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of Mar 26 30
Was there an autopsy? no
What test confirmed diagnosis? approximation

(Signed) D. L. Lynn, M. D.
3/28, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Idaho.	March 30 1930
20. Undertaker D. L. McLean	Address Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

69723

DO NOT WRITE IN THIS SPACE
State File No. 69723

County of Ada
City of Collister Station
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 24
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Collister 74a 10

(a) Residence. No. Collister Station St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Geo. Collister

6. DATE OF BIRTH (month, day and year) Nov. 26-1857

7. AGE Years 72 Months 3 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Mr. Elliott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Cynthia Ann Rouse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Am.

14. Informant W. E. Cook
(Address) Ola, Ida.

15. Filed 3-11, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1929, to March 1st, 1930
that I last saw her alive on March 1st, 1930
and that death occurred, on the date stated above, at 12 45 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
about (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical examination
(Signed) H. C. Dedman, M. D.
Mar. 10, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 3/10 1930

20. Undertaker Schreiber & McCann Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69724

PLACE OF DEATH
County of Ada
City of Meridean

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

33

2. FULL NAME Annie Blanche Clark
(a) Residence. No. Idaho St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 22 1880
7. AGE: Years 49, Months 9, Days 28; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teaching
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Marysville
(State or country) Blount Co. Tenn.

PARENTS
10. NAME OF FATHER James Richard Clark
11. BIRTHPLACE OF FATHER (city or town) Marysville
(State or Country) Blount Co. Tenn.
12. MAIDEN NAME OF MOTHER Malvina Josephine Singleton
13. BIRTHPLACE OF MOTHER (city or town) Louisville
(State or Country) Blount Co. Tenn.

14. Informant James R Clark
(Address) Meridean, Idaho
15. Filed 2-20, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 12-23-, 1929, to 2-19, 1930
that I last saw her alive on 2-19, 1930
and that death occurred, on the date stated above, at 3.30 P. m.
The CAUSE OF DEATH* was as follows: Tuberculin Intestines
(duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1-6-30
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H F Neal, M. D.
2-20, 1930 (Address) Meridean Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: Feb 21 1930
20. Undertaker: N S Mathews Meridian Id. — Address

Book.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69725

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 30

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Mariette Selleck Bower

(a) Residence. No. 2 miles South of Boise St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-13 1839

7. AGE Years 90 Months 7 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Conn

PARENTS
10. NAME OF FATHER Albert Selleck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Conn
12. MAIDEN NAME OF MOTHER Celina Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Conn

14. Informant (Address) Mrs. Fred E. Williams R.D. #4 Boise Idaho

15. Filed 3-24 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th 1930, to March 21st 1930
that I last saw her alive on March 21st 1930
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hypostatic pneumonia

..... (duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) John Bouk, M. D.
3-22 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Mar 24 1930

20. Undertaker Summers & Krebs
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69726

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 26

(No. Boise, Idaho. Route #2)

(If death occurred in a hospital or institution, give its name instead of street and number.)

6885

2. **FULL NAME** James S. Scott.

(a) Residence. No. Boise, Idaho. Route #2. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mollie Scott.

6. DATE OF BIRTH (month, day and year) December 3rd 1862

7. AGE Years	Months	Days	If LESS than 1 day, ——— hrs. or ——— min.
84	3	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant Mattie L. Kingsley.
(Address) Hermiston, Oregon.

15. Filed 3-13, 1930 W. J. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11th 1930 (Day), 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Mar 11th, 1930 that I last saw him alive on Feb 28, 1930 and that death occurred, on the date stated above, at 11.50 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. W. Bratney, M. D.

3/12/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 3/13/30, 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PHYSICIAN

MARION RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69727

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 204

Local Registrar's No. 25

(No. Near Dry Creek Cemetery)

(If death occurred in a hospital or institution, give its name instead of street and number.)

4031

2. FULL NAME Jennie Ellen Lane

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C. O. Lane

6. DATE OF BIRTH (month, day and year) Aug 29, 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	6	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Wm Woods

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mont Knox

12. MAIDEN NAME OF MOTHER — Eastepp

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont Knox

14. Informant C. O. Lane
(Address) Boise Ida

15. Filed 3-11, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2-17, 1930, to 2-17, 1930
that I last saw her alive on 2-17, 1930
and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:
Myocarditis with
Brights disease

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. F. Neal, M. D.
3. 11, 1930 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Ida	3/12 1930
20. Undertaker E. W. Robison	Address Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69728

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 23
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 164

2. FULL NAME Anna M Jensen
(a) Residence. No. 7 Miles N. W of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 10, 1833

7. AGE Years 97 Months 1 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Jake Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Jake Jensen R 2 Box 1, Boise Idaho

15. Filed 3-6, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to —, 19
that I last saw her alive on March 3, 1930
and that death occurred, on the date stated above, at 3 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold W Stone, M. D.
3/5, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Dry Creek Cemetery
Date of Burial Mar 5 1930

20. Undertaker Summers & Krebs
Address Boise Idaho

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69729

Local Registrar's No. 22

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

(No. U.S.Vet.Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90 B

2. FULL NAME Andrew H. MC GREGOR

(a) Residence. No. ..... St. Ontario, Oregon
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. X yrs. X mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of XX

6. DATE OF BIRTH (month, day and year) 6-28-1845

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	8	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: Andrew McGregor

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 3-10, 1930 W. T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 17, 1930, to March 8, 1930
that I last saw him alive on March 8, 1930
and that death occurred, on the date stated above, at 11 P.M. m.
The CAUSE OF DEATH* was as follows:

Cardiac Dilatation, acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C.SMITH, Reg.Med.Officer, M. D.

Mar. 10, 1930 (Address) U.S.V.Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ontario, Oregon	19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69730

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 93
(No. 612 Pioneer St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

15-93

2. FULL NAME Raymond John Fackrell.

(a) Residence. No. 612 Pioneer St. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 29th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	1

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER David K. Fackrell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Orderbille, Utah.
12. MAIDEN NAME OF MOTHER Elsie Evelyn White.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bonita, Oregon.

14. Informant D. K. Fackrell.
(Address) Boise, Idaho.

15. Filed 3-31, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29, 1930, to Mar 29, 1930, that I last saw h[illegible] alive on Mar 29, 1930 and that death occurred, on the date stated above, at 4:45 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Congenital defect in heart. Bleu
Lobular
Lasted 30 minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) O. R. Bovard M. D.
3/29/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 3/29/30 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69731

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 92

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Helena Briggen

(a) Residence. No. ..... St. Crane, Ore.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. E. Briggin

6. DATE OF BIRTH (month, day and year) June 17-1870

7. AGE Years 52 Months 9 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mount Blakeny, Lumeric Co Ireland

PARENTS

10. NAME OF FATHER Daniel O'Brien

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mount Blakeny Lumeric Co Ireland

12. MAIDEN NAME OF MOTHER Helena Hearlehy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Margaret McBriggen
(Address) Boise Idaho

15. Filed 3-31, 1930 W. H. Rhodes R. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Mch 27, 1930

that I last saw her alive on Mch 27, 1930

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows: Metastatic Cancer of the Lung

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Cancer of Breast

..... (duration) 1½ yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Grogan Ore

Did an operation precede death? Yes Date of June 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Joseph Stewart, M. D.

Mch 28, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John's Cemetery — Date of Burial 3/29 1930

20. Undertaker Schreiber & McCann — Address Boise, Ida

Burdge

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69732

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 91
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Ella McFarland.
(a) Residence. No. Boise, Idaho. R#1. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. K. McFarland.

6. DATE OF BIRTH (month, day and year) February 10th 1856

7. AGE Years 74 Months 1 Days 16 If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER Jacob Thornton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Maria Brunck.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant (Address) C. K. McFarland. Boise, Idaho.

15. Filed 3-28, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to March 26, 1930 that I last saw her alive on March 26, 1930 and that death occurred, on the date stated above, at 4 P.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings & laboratory
(Signed) Alfred Bridge E Jr, M. D.
3/28/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 3-28 1930

20. Undertaker Wm. McBratney. Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69733

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 90
(No. Idaho Soldiers Home Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Goodman
(a) Residence. No. Soldiers Home St. 164
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1853

7. AGE 76 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran Indian
(b) General nature of industry, business, or establishment in which employed (or employer) Wars
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) E G Beernet Idaho Soldiers Home Boise Ida

15. Filed 3-27, 1930 W. H. Kaden Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/1, 1930, to 3/26, 1930
that I last saw him alive on 3/25, 1930
and that death occurred, on the date stated above, at 3:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia Intestinal

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptom
(Signed) Fred A Pittenger, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial May 28 1930
20. Undertaker Summers & Krebs
Address Boise Id.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69724

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 89
(No. 164)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tillie B. Cupit

(a) Residence. No. 717 N. 14 St
(Usual place of abode.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 23-1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ills
(State or country)

PARENTS

10. NAME OF FATHER George Penney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Bascombe
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Dr. P. P. French 1407 Hayes St Boise Ida

15. Filed 3-26, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to March 23, 1930
that I last saw her alive on March 23, 1930
and that death occurred, on the date stated above, at 2.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Severe Cold, Senility

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French M. D.
March 26, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Mar 26 1930
20. Undertaker: Summers & Trefs — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69735

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 88
(No. 1403 Harrison Blvd.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mrs. Augusta Wootan
(a) Residence. No. 1403 Harrison Blvd. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James Wootan

6. DATE OF BIRTH (month, day and year): January 3rd 1847

7. AGE: Years 83, Months 2, Days 20. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: Willhelm Matschofs.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Germany.

14. Informant (Address): Arthur B. Golden. Boise, Idaho.

15. Filed 3-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23rd 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1927, to March 1930
that I last saw her alive on 23 March 1930
and that death occurred, on the date stated above, at 9:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. — mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 1 yrs. 2 mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
3/24/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 3/27/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69736

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. St Luke's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

88B-HP

2. FULL NAME William W. Matlock

(a) Residence. No. ..... St. Meridian Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of

6. DATE OF BIRTH (month, day and year) April 15 - 1857

7. AGE: Years 72 | Months 11 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER: Clinton Matlock

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Susan Weaver

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tennessee

14. Informant: James William Matlock
(Address) Meridian R.D. 2.

15. Filed 3-24, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 9, 1930, to Mch 21, 1930

that I last saw him alive on Mch 21, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Arteriosclerosis (Terminal)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Meridian Ida

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory

(Signed) James L. Stewart, M. D.

3/27, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery | Date of Burial: 3-23 1930

20. Undertaker: W. S. Mateer | Address: Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

69737

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69737

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No.

(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Martinez Sr.

(a) Residence. No. ... St. Emmett, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Juana Martinez

6. DATE OF BIRTH (month, day and year) 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Boise Payette L. Co.

9. BIRTHPLACE (city or town) (State or country) Spain.

PARENTS

10. NAME OF FATHER Not Obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain

12. MAIDEN NAME OF MOTHER Not Obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain

14. Informant Benito Ysursa

(Address) Boise Idaho

15. Filed 3-24, 1930 W. F. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 28, 1930, to March 18, 1930
that I last saw him alive on March 18, 1930
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sperix

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold W. Stone, M. D.

3/20, 1930 (Address) 317 Eastman Bldg Boise.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	3/22 1930
20. Undertaker	Address
Schreiber & McCann Stone	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69738

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 16
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs. Susan Strahler

(a) Residence. No. Meridian R.F. #2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Alois Strahler

6. DATE OF BIRTH (month, day and year) Jan 19, 1884

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	2	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rocky Bar Idaho

PARENTS

10. NAME OF FATHER Tom Mowrer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Ann McIntyre
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Alois Strahler Meridian R.F. #2

15. Filed 3-24, 1930 (W.) A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/16, 1930, to 3/22, 1930
that I last saw her alive on 3/22, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
erysipelas of face and head.
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) influenza
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) N. F. Neal, M. D.
3-24, 1930 (Address) Meridian

19. Place of Burial, Cremation, or Removal: Caldwell Idaho. Date of Burial: Mar 25 1930
20. Undertaker: Summers & Kuhn. Address: Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69739

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8
149
201

2. FULL NAME George Frederick Butler
(a) Residence. No. 1502, N. 18 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 7- 1841.

7. AGE Years: 78 Months: 3 Days: 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Land
(b) General nature of industry, business, or establishment in which employed (or employer): appraisor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: Samuel G Butler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant (Address): Mrs. J. T. Fisher 1502 N. 18 st Boise Ida

15. Filed 3-22, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-3, 1930, to Mar 20, 1930
that I last saw him alive on Mar 20, 1930
and that death occurred, on the date stated above, at 12:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fracture of Femur (accidental)

(duration) ..... yrs. ..... mos. 45 ds.

CONTRIBUTORY (Secondary): Chronic Cholecystitis + Colitis + senility (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Boise Ida.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? X-ray + autopsy
(Signed) J Reno Numbers, M. D.
Mar 21, 1930. (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Long Beach Calif
Date of Burial: Mar 25 1930

20. Undertaker: Summers & Krebs
Address: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69740

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 83
(No. St. Alphonsus) HP 125
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lizzie McKee

(a) ~~Residence. No.~~ (Usual place of abode) Owyhee Nevada St. Owyhee Nevada
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	4/4 Indian	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. McKee

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Owyhee Nevada

PARENTS

10. NAME OF FATHER Louis Dick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Owyhee Nevada
12. MAIDEN NAME OF MOTHER Emma Dick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Owyhee Nev.

14. Informant Chas. McKee
(Address) Owyhee Nev

15. Filed 3-21, 1930 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3/21 (Month) (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/20, 1930, to 3/21, 1930
that I last saw her alive on 3/21, 1930
and that death occurred, on the date stated above, at 8 30 A. m.
The CAUSE OF DEATH* was as follows:

Shock Acute Pancreatitis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Colecystitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Owyhee Nev
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Fred. A. Ridenyer, M. D.
3/21, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. Shipment

19. Place of Burial, Cremation, or Removal: Owyhee, Nev. Date of ~~Burial~~: 3/21 1930

20. Undertaker: Schreiber & McCann Address: Boise.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69741

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No.

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter J. Brown.

(a) Residence. No. Collister Station, Boise, Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Brown.

6. DATE OF BIRTH (month, day and year) July 21st 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or mm.
65	7	25	0----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Well Driller

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Smithburg, Md.

PARENTS

10. NAME OF FATHER John Brown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Md.

12. MAIDEN NAME OF MOTHER Margaret Ann Fox.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Md.

14. Informant Mrs. Mazie Rounds.
(Address) Boise, Idaho.

15. Filed 3-17, 19 30 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1930, to March 16 1930, that I last saw him alive on March 16, 1930, and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina suffocation
factors

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos C Hunt, M. D.

3/17/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	3/19/30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69742

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 119
(No. Idaho Soldier's Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Richard Harris.

(a) Residence. No. Salmon, Idaho. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~Single~~, ~~Married~~, Widowed, or ~~Divorced (write the word)~~
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1872

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Spanish American War Veteran.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Harford, Mich.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Mr. Burnet. Boise, Idaho.

15. Filed 3-19, 1930 W. N. Rich Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/15, 1930, to 3/17, 1930
that I last saw ~~him~~ alive on 3/17, 1930
and that death occurred, on the date stated above, at 9:50 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthenia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Fred A Fatungle, M. D.
3/18/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Salmon, Idaho. Date of Burial: Shipped 3/19/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

January

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69743

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 48

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Mrs. Wanda May Cummings.

(a) Residence. No. 1202 N. 16th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Cummings.

6. DATE OF BIRTH (month, day and year) June 17th 1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	8	29	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester, Ind.

PARENTS

10. NAME OF FATHER L. D. Johnson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Myrtle Truman.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) California.

14. Informant L. D. Johnson.
(Address) Boise, Idaho.

15. Filed 3-18, 1930 W. L. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to March 16, 1930
that I last saw h[illegible] alive on March 16, 1930
and that death occurred, on the date stated above, at 12 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Chas. C. Geroway, M. D.
3/18/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	3/19/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69744

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 79

PLACE OF DEATH
County of Ada
City of Boise
(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Sample

(a) Residence. No. 610 South 15th St.
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) About 1865

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	65	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: General Home Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant A. Schreiber
(Address) Boise

15. Filed 3-18, 1930 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1930 to Mar 14, 1930
that I last saw her alive on Mar 13, 1930
and that death occurred, on the date stated above, at 11:25 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 5 yrs. 3 mos. 14 ds.
CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Home
(Signed) F. C. Brayton, M. D.
Mar 17, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	3/18 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Bosch RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69745

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 70
(No. 1108 N. 10th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frazier Smith.
(a) Residence. No. 1108 N. 10th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Smith.

6. DATE OF BIRTH (month, day and year) June 2th 1850

7. AGE Years 79 Months 9 Days 14 If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10. NAME OF FATHER Robert Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Ella Frazier.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland.

14. Informant (Address) Mrs. Etha Headricks. Boise, Idaho.

15. Filed 3-17, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 16th 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-15-, 1930, to 3-16-, 1930
that I last saw him alive on 3-15-, 1930
and that death occurred, on the date stated above, at 12:15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage on brain - complete paralysis -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility & High blood pressure (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bost M. D.
3/17/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 3/17/30 19
20. Undertaker Wm. McBratney. Address Boise, Idaho.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69746

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 77

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles M. Wilmot.

(a) Residence. No. Eagle, Idaho. R.#1. St. 90

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 33 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence Wilmot.

6. DATE OF BIRTH (month, day and year) November 24th 1845

7. AGE Years	Months	Days	If LESS than 1 day, ... min.
67	3	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Charles, Minn.

PARENTS

10. NAME OF FATHER Wilbur Wilmot.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) W W

14. Informant (Address) Earl Wilmot. Boise, Idaho.

15. Filed 3-13, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1-, 1930, to 3-11-30, 19....
that I last saw h— alive on 3-10-30, 19....
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Thrombosis

Mesentery Artery (duration) ....yrs. ....mos. 1 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 3-11-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Ernest E. [illegible], M. D.

3-13-, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	3/13/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69748

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 75
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlotte Laura Tabor 74a
(a) Residence. No. 1301 N 22 St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-23-1864

7. AGE 66 Years | Months 0 | Days 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER David Snider
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va
12. MAIDEN NAME OF MOTHER Rebecca J. Snider
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Va

14. Informant (Address) Mrs. Mabel Emmett Genesee Idaho

15. Filed 3-13, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1916, to Mar 9, 1930
that I last saw him alive on March 9, 1930
and that death occurred, on the date stated above, at 8 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 12 hr

CONTRIBUTORY (Secondary) Arterio Sclerosis & Hypertension (duration) 15 yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Cur. & Sphygmoma
(Signed) T. M. Brayton M. D.
Mar 10, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery | Date of Burial Mar 11 1930
20. Undertaker Summers & Krebs | Address Boise Idg.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69749

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1204
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 74
B 74B

2. FULL NAME Henry Lytle

(a) Residence. No. 0 St. Emmett, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Blanch Lytle

6. DATE OF BIRTH (month, day and year) Oct. 12 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	4	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Saw-Mill
(c) Name of employer Boise Pyt Idaho

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER [illegible] Lytle
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Fred Gardner
(Address) 510-N. 2nd Boise Ida

15. Filed 3-10, 1930 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 9, 1930
that I last saw h/m alive on March 8, 1930
and that death occurred, on the date stated above, at 1 50 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Prostatic abscess
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death? Home at Emmett Ida.
Did an operation precede death? Yes Date of March 1 30
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) W. A. Foisel, M. D.
3-10, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett, Ida. — Date of Burial: Mar. 9 1930
20. Undertaker: O. D. Tuckerman — (Address) Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69750

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 7
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mabel White. 7 B
(a) Residence. No. 2212 Harrison Blvd. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William A. White.

6. DATE OF BIRTH (month, day and year): December 25th 1876

7. AGE: Years 53 | Months 2 | Days 11 | ~~If LESS than 1 day~~ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Des Moines, Iowa.

PARENTS
10. NAME OF FATHER: Levi Gibson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County):

14. Informant (Address): Mrs. Donald Atwood. Boise, Idaho.

15. Filed 3-10, 1930 W. W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 6th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15th, 1920, to March 6th, 1930 that I last saw her alive on March 6th, 1930 and that death occurred, on the date stated above, at 11:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Complete Paralysis following many consecutive hemorrhages of brain - with high blood pressure (duration) years mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ken Boeck, M. D.
3/7/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 3-9-30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69751

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 99
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Martin Giel 99 B

(a) Residence. No. 420 S. 3 st St.
(Usual place of abode.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Veteran of Civil War
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mercersburg Indiana

PARENTS

10. NAME OF FATHER James Giel.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Harriet Rawhouse
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) Mrs C E Callison 420 S. 3 st Boise Idaho

15. Filed 3-10, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to 3/8, 1930
that I last saw him alive on 3/6, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
(Angina Pectoris)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there autopsy? no
What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A Pomeroy M.D.
3/9, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Mar 10 1930
20. Undertaker: Summers & Kirk — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69752

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

48a B

2. FULL NAME Mamie Nappier

(a) Residence. No. 109 South 3th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of M. T. Nappier

6. DATE OF BIRTH (month, day and year) Jan 23. 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	1	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City

PARENTS

10. NAME OF FATHER George Judd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Vevenna Knowlton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs William Frosting
(Address) 344 Cedar St Nampa Ida

15. Filed 3-10, 1930 W. F. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Feby 6, 1930, to Mch 7, 1930
that I last saw her alive on Mch 7, 1930
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis with dilitation and decompensation.
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Ida
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & X ray
(Signed) James K Stewart, M. D.
3/8, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	3/9 1930
20. Undertaker	**Address**
Schreiber & McCann	Boise

TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69753

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

2. FULL NAME John Edward Brown 49 B

(a) Residence. No. 1124 Grand Ave St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Dark
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Apr 9 - 1871

7. AGE: Years 58, Months 10, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): Elks Lodge #310
(c) Name of employer: " " "

9. BIRTHPLACE (city or town) (State or country): Not obtainable

PARENTS
10. NAME OF FATHER: " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: C. W. Johnson Secy
(Address) 82 - Jeff St Boise } Elks Lodge

15. Filed 3-8, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6th, 1930, to March 6th, 1930 that I last saw him alive on March 6th, 1930 and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ——

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
March 7th 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 3/9 1930

20. Undertaker: Schreiber & McCann
Address: Boise

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69754

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 67
(No. Idaho Soldiers Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James S. Grier
(a) Residence. No. Idaho Soldiers Home St. 164 B
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug-10,-1845
7. AGE Years 84 Months 6 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of Civil
(b) General nature of industry, business, or establishment in which employed (or employer) War.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) E. G. Burnet Idaho Soldiers Home Boise Ida
15. Filed 3-6, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 3, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to 3/3, 1930
that I last saw him alive on 3/2, 1930
and that death occurred, on the date stated above, at 30 m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Micardial Degeneration
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical finding
(Signed) Fred A. Patterson, M. D.
3/5, 1930 (Address) Boise Id

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Mar. 7 1930
20. Undertaker: Summers & Krebs
Address: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69755

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 66
(No.) Idaho Soldiers Home Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Augustus Lafayette Ward
(a) Residence. No. Soldiers Home St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 12, 1842

7. AGE Years 87 Months 6 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cincinatti Ohio

PARENTS
10. NAME OF FATHER Joshua Ward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Nancy Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) G. H. Talley 1912 N. 22 st Boise Idaho

15. Filed 3-6, 1930 W. H. Rho[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930 to 3/4, 1930
that I last saw him alive on 3/4, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Micardial Degeneration
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symp
(Signed) Fred A Pateugh M. D.
3/5, 1930 (Address) Boise Id

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Mar 6 1930

20. Undertaker Summers & Krebs
Address Boise Idaho

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69756

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. [illegible]
Local Registrar's No. 67
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

B 46

2. FULL NAME Mrs. Harriett Pearl Cooper

(a) Residence. No. 413 South 5th Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William P. Cooper

6. DATE OF BIRTH (month, day and year) August 23rd 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	6	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mercer Co. Ill

PARENTS

10. NAME OF FATHER Ambrose Sproston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mercer Co. Ill.

12. MAIDEN NAME OF MOTHER Senora Dunnaain.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant Mrs. Frances Aitchison
(Address) Boise, Idaho.

15. Filed 3-4, 1930 W. W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 3rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Mar 2, 1930
that I last saw her alive on 3/1, 1930
and that death occurred, on the date stated above, at 4:00 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Post Operative Paralytic Illeus.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Cervix
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes. Date of 2/17/30
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Symptom

(Signed) Fred A. Tuttle M. D.
3/3/30, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Meadows, Idaho.	3/6/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69757

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 66

Pr 105

2. FULL NAME Mrs. Catherine Byrne
(a) Residence. No. 212 E. Bannock St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 24-1844

7. AGE: 85 Years | Months: 2 | Days: 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Eephin Co Roscommon Ireland.

PARENTS

10. NAME OF FATHER: Thomas Dolan.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Eephin Co Roscommon Ireland.
12. MAIDEN NAME OF MOTHER: Cathrine ~~Dolan~~ Reynolds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Eephin Co Roscommon Ireland

14. Informant: M. J. Byrne
(Address): Route 2 Boise

15. Filed 3-4, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/28, 1930, to 3/2, 1930
that I last saw her alive on 2/28, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Cardio-Vascular Degeneration Asthma
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Myocardial Degeneration
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) Fred A. Tolinger M. D.
3/3, 1930 (Address) Boise Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: St. John's Cemetery | Date of Burial: 3/3 1930.

20. Undertaker: Schreiber & McCann | Address: Boise

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69758

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004

Local Registrar's No. 65

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

B 29

2. FULL NAME Charles Stearns Bostwick

(a) Residence. No. 920 Warm Springs St.
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 9 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Mining
(b) General nature of industry, business, or establishment in which employed (or employer) Man
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Victor M. Bostick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Flora Weider
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs. Tate Davidson
(Address) 920 W. S. Boise Idaho

15. Filed 3-4, 1930 W. F. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2, 1930, to Mar 2, 1930
that I last saw h[illegible] alive on Mar 2, 1930
and that death occurred, on the date stated above, at 3 10 m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) L. Sweeney, M. D.
3/3, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Montana	Mar 6 1930
20. Undertaker	Address
Summers & Kubs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Frazier

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69759

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

2. FULL NAME Isaac Hargraves

(a) Residence No. 1412 W. 14 St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

57

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Hargraves

6. DATE OF BIRTH (month, day and year) April 3 - 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66,	10	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Charles Hargraves
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Charles Hargraves
(Address) 615 N 18 St Boise Idaho

15. Filed 3-4, 1930 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Feb 28, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: diabetes Mellitus

(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pancreatitis
(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual diabetic tests
(Signed) W L Thorne, M. D.
Mar 3, 1930 (Address) 303 Eastman Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Mar 4 1930
20. Undertaker	Address
Summers & Kraft	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 9 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adams

City of Indian Valley

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 69760

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph James Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. March (Month) 4 (Day) 1930 (Year)

7. AGE ..... Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... No

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Adams Co Ida

10. NAME OF FATHER Earl Byers

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Nellie Murphy

13. BIRTHPLACE OF MOTHER (State or Country) Adams Co Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Byers

(Address)

15. Filed 4-7-30 191 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 4 (Day) 1930 (Year) 162

17. I HEREBY CERTIFY, That I attended deceased from Mar 9 1930, to Mar 9 1930, that I last saw him alive on Mar 9 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hephanation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Double Hernia

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt D.C. ~~M. D.~~

..... 19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Indian Valley Ida

DATE OF BURIAL 4-5 1930

20. UNDERTAKER J A Hudelson

ADDRESS Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 5 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 69761

Registered No. .....

1. PLACE OF DEATH. Registration District No. .....

County of Adams

Primary Registration District No. .....

City of Cambridge (If outside limits of city or village give township) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alberta Bernice Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 11 (Day) 1920 (Year)

7. AGE: ....Yrs. 12 Mos. ....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Nil

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Adams Co Ida

10. NAME OF FATHER: Wm. Murphy

11. BIRTHPLACE OF FATHER (State or Country): Adams Co Ida

12. MAIDEN NAME OF MOTHER: Florence Jackson

13. BIRTHPLACE OF MOTHER (State or Country): Adams Co Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W M Murphy

(Address) .....

15. Filed 4-3-30 191.... W M Evans Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH [illegible] (Month) 29 (Day) 191[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-11-30 191.... to 3-29-30 191....,
that I last saw h[illegible] alive on 3-29-30 191....,
and that death occured on the date stated above, at 12:00 M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

.....(Duration) Yrs. mos. ds.

Contributory (Secondary) Premature delivery

.....(Duration) Yrs. mos. ds.

(Signed) W M Evans M D

19.... (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jordan Valley

DATE OF BURIAL: 2-[illegible] 191[illegible]

20. UNDERTAKER: [illegible]

ADD[illegible]

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69762

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 25
Primary Registration District No. 2161
Local Registrar's No. 5785

(No. Keystone Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4980

2. FULL NAME Joseph Fletcher

(a) Residence. No. Twin Falls, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Scarborough

6. DATE OF BIRTH (month, day and year) July 11, 1851.

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	8	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs. C. V. Hinkle
(Address) Twin Falls, Idaho

15. Filed 3/18, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. V. Houde M.D. acting Coroner, M. D.
3/18/30, 19... (Address) 425 W. Center St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho.	3/21/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69763

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Dean A. Young
(a) Residence. No. 625 West Bridger Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Norma Jean Haskett

6. DATE OF BIRTH (month, day and year) January 10, 1905.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
25	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mail Carrier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: U. S. A.

9. BIRTHPLACE (city or town) (State or country): Oakland, Nebraska.

PARENTS

10. NAME OF FATHER: Louis L. Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Arizona, Nebraska.
12. MAIDEN NAME OF MOTHER: Helen D. Sackett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: Mrs. Louis L. Young
(Address) 215 7th. Ave. South, Nampa, Ida.

15. Filed 3/18, 1930 J. L. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17, 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 3/15, 1930, to 3/17, 1930
that I last saw him alive on 3/17, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Acute Pustured Appendix.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 3/16/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A P Groom M. D.
3/18/30. 19 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa, Idaho. Date of Burial: 3/20/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69764

PLACE OF DEATH
County of Power
City of McDougall Airport

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5783
(No. About One & One-half Miles North of Airport)
(If death occurred in a hospital or institution, give its name instead of street and number.)

198 D

2. FULL NAME Merle P. Morgan
(a) Residence. No. 1006 East Wyeth St. Poca., Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Sybil Park
6. DATE OF BIRTH (month, day and year): Sept. 5, 1891.
7. AGE: Years 38, Months 6, Days 7. If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Advanced Student Airplane Pilot
(c) Name of employer: None
9. BIRTHPLACE (city or town) (State or country): Carthage, Missouri.

PARENTS
10. NAME OF FATHER: Samuell W. Morgan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Charlott Lee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs. Merle P. Morgan
(Address) 1006 East Wyeth St. Poca. Ida.

15. Filed 3/15, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 12, 1930. (Month) (Day) (Year) 19__

17. I HEREBY CERTIFY, That I attended deceased from ___, 19__, to ___, 19__
that I last saw h___ alive on ___, 19__
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
Burned to Death in Airplane
Following crash
Cause of crash unknown
___ (duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) ___
___ (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ___
Did an operation precede death? ___ Date of ___
Was there an autopsy? ___
What test confirmed diagnosis? ___
(Signed) [signature] Corner
3-13, 1930 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Amherstburg, Ontario. Canada. Date of Burial: 19__
20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69765

PLACE OF DEATH
County of Bannock
City of Lava Hot Spring

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5782

(No. Residence Lava Hot Springs, Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Adolph Solomon Clark
(a) Residence. No. Lava Hot Springs Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Connell.
6. DATE OF BIRTH (month, day and year) Jan 11, 1879.
7. AGE Years 51. Months 1 Days 28 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None.
9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS
10. NAME OF FATHER Alexander Clark.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Dollymay Clark
(Address) Lava Hot Springs, Idaho.
15. Filed 3/12/, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb, 1926, to Mar 9, 1930
that I last saw him alive on March 9, 1930
and that death occurred, on the date stated above, at 9 55 a m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) C. A. Rich M. D.
3-9-, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Brule, Nebraska. Date of Burial 3/14/30. 19
20. Undertaker Arthur W. Hall Address Pocatello.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69766

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 708 So Main St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5781

129

2. FULL NAME Mrs Ellen Yardley
(a) Residence. No. 708-N. Main St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 59 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS
10. NAME OF FATHER: Isaac Rosenbaum
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Caasey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: Veda Marten
(Address) 816-So. Main St.

15. Filed March 8, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1930, to Mar. 8, 1930
that I last saw her alive on Mar. 8, 1930
and that death occurred, on the date stated above, at 3:40 P.m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
myocarditis chronic
~~[illegible]~~
(duration) several years. yrs. mos. ds.
CONTRIBUTORY (Secondary) uremia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? chronic condition
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? urinary tests
(Signed) H. H. Hughart, M. D.
Mar. 10, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sheridian Wyo. | Date of Burial: Mar. 12 1930

20. Undertaker: H. L. McHan | Address: Poca. Ida.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69767

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5780

74a

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 431 So 6th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mattie Drumond Weideman

(a) Residence. No. 431 So 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Fred Weideman

6. DATE OF BIRTH (month, day and year) Jan 27th 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Drummond
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Booker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Fred Weideman
(Address) Pocatello Idaho

15. Filed 3/8, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8, 1930, to 3-8, 1930
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 6.30 A m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature] M. D.
3/8, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	3/11 1930
20. Undertaker	Address
Schumacher & Beasley	Caly

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

St Reg

DO NOT WRITE IN THIS SPACE
State File No. 69768

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216
(No. north of City)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5779

206

2. FULL NAME Infant Leach.
(a) Residence. No. north of City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Premature Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Margaret Leach.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: Mrs J Leach
(Address): Pocatello Idaho

15. Filed 3/8, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to 3-6, 1930
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Premature birth
5 mo.
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr C Ray, M. D.
3-7, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 1930
Mt View	
20. Undertaker	Address
Schumacher & Beasley	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69769

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Hospital Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5778

129

2. FULL NAME Anna Victoria Lambert

(a) Residence. No. 1500 South Second Ave. Poca. Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of Charles Lambert

6. DATE OF BIRTH (month, day and year) January 25, 1896.

7. AGE	Years	Months	Days	If LESS than 1 day,
	34	0	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sandy, Utah.

PARENTS

10. NAME OF FATHER: Charles J. Swenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Anna Johanna Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Charles Lambert
(Address) 1500 South Second Ave. Poca., Ida.

15. Filed 3/6, 1930. J. H. Lynn. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Mar 5, 1930
that I last saw her alive on Mar 5, 1930
and that death occurred, on the date stated above, at 8:50 a. m.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
Nephritis
(duration) 5 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) — yrs. 1 mos. — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no What test confirmed diagnosis? Physical findings
(Signed) J. H. Lynn, M. D.
3/6/30., 19 (Address) Poca. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	3/7/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69770

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No.
Primary Registration District No. 2161
Local Registrar's No. 5227

(No. 645 South Sixth Ave. Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME Mary Chandler

(a) Residence. No. 645 South Sixth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of Thomas Chandler

6. DATE OF BIRTH (month, day and year) April 19, 1857.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: John Catmull
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Susan Arbon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Thomas Chandler
(Address) 645 South Sixth Ave. Poca., Ida.

15. Filed 4/6, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to Apr. 4, 1930
that I last saw h-r alive on Apr. 4th, 1930
and that death occurred, on the date stated above, at 5.10 a m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrage or Apoplexy.
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) J. F. Miller, M. D.
4/5/30 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/6/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69771

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5776

(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Martin D. Farris

(a) Residence. No. 852 So. 2nd St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 23-1927

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	3-		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Press T. Farris

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Pres Louis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Old Mexico

14. Informant Press T. Farris
(Address) 852 So. 2nd Ave

15. Filed Mar 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930 to Mch 4, 1930
that I last saw him alive on Mch 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Respiratory So Grippe

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia x meningitis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray, M. D.

B-4, 1929 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial 19

20. Undertaker: H. L. McKan — Address: Poca Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69772

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2
Primary Registration District No. 2161
(No. 263 Wayne Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2773

161a

2. FULL NAME Jane Edward Jensen
(a) Residence No. 263 Wayne Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 4-1930

7. AGE: ✓ Years: ✓ Months: ✓ Days: ✓ If LESS than 1 day, 1 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER Robert Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Vivian Andrews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Robert Jensen
(Address) 263 Wayne Ave

15. Filed Mar. 4, 1930 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on 3-4-30, 19...
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Premature birth (8th mo)
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Instrumental delivery
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. Smiller, M. D.
3/4, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery
Date of Burial: Mar. 4 1930

20. Undertaker: H. T. McHan
Address: Poca. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE... APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69773

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony Hospital Poca.,)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5798
161a

2. FULL NAME Joyce Ellen Myers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1, 1930.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
0	0	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Ida.

PARENTS

10. NAME OF FATHER: N. A. Myers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden, Utah.
12. MAIDEN NAME OF MOTHER: Ellen Bradley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden, Utah.

14. Informant: N. A. Myers
(Address) 165 Roosevelt Ave. Poca., Ida.

15. Filed 4/5, 1930. J. R. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 5, 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mch 31, 19..., to Apr 5, 1930
that I last saw her alive on Apr 5, 1930
and that death occurred, on the date stated above, at 11 30 a m.
The CAUSE OF DEATH* was as follows:
Premature - Inanition
Mother Eurenic

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. C. Ray, M. D.
4/5/30., 19... (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho.
Date of Burial: 4/6/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69774

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 24
Primary Registration District No. 2161
Local Registrar's No. 5797

(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

184

2. FULL NAME Geraldine Marie Riddell

(a) Residence. No. 1018 North Harrison Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 29, 1927.

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	4	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER W. F. Riddell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richmond, Virginia.

12. MAIDEN NAME OF MOTHER Ellen Pearl Olson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pocatello, Idaho.

14. Informant W. F. Riddell
(Address) Pocatello, Idaho.

15. Filed 4/4, 1930. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Skull fracture hit by car
Driven by Mr. D. B. Eleazer
(accidental)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner M. D.
4/4/30., 19... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/4/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69775

Local Registrar's No. 5796

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. 1018 North Harrison Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Sarah Ellen Olsen

(a) Residence. No. 1018 North Harrison Ave. Poca., St.
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of Martin Olsen

6. DATE OF BIRTH (month, day and year) November 8, 1867.

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	4	23	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER David Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant George Olsen
(Address) 1018 North Harrison Ave. Poca.,

15. Filed 4/3, 1930. J. H. Hancock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-16, 1930, to 3-30, 1930
that I last saw h[illegible] alive on 3-30, 1930
and that death occurred, on the date stated above, at 5a. m.
The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings

4/2/30. (Signed) [signature] M.D.
(Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69776

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 12
Primary Registration District No. 2161
Local Registrar's No. 5795
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant King

(a) Residence. No. General Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	Ten hrs. & 45 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER W. J. King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina,
12. MAIDEN NAME OF MOTHER Clara Irene Fairman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant W. J. King
(Address) 815 East Clark St., Poca., Ida.

15. Filed 3/31, 1930 J. P. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/30, 1930, to 3/31, 1930
that I last saw her alive on 3/31, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Abruptio Placenta —
Suffocation —
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. P. Young M.D.
3/31/30., 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	3/31/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69777

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 25
Primary Registration District No. 216
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5794

2. FULL NAME Dorathy May Weatherington 90
(a) Residence. No. 712 So 4th Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Weatherington

6. DATE OF BIRTH (month, day and year) May 31/8/45

7. AGE: Years 85 | Months 2 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper,
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER: Wm. Hayes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elisabeth Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs. Ed Weatherington
(Address) 712 So. 4th Street

15. Filed 3/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to Mar 29, 1930
that I last saw her alive on Mar 29, 1930
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows: Cardio Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
3/30, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho
Date of Burial: 3-30 1930

20. Undertaker: H. L. McHan
Address: Poc. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69779

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5291

(No. Lynn Hospital Pocatello)

(If death occurred in a hospital or institution, give its name instead of street and number.)

184

2. FULL NAME Calvin Carl Pehrson

(a) Residence. No. 1144 North Main Street St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 27, 1926.

7. AGE

Years	Months	Days	If LESS than 1 day,
4	2	0	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho.

PARENTS

10. NAME OF FATHER: Joseph W. Pehrson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pocatello, Idaho.

12. MAIDEN NAME OF MOTHER: Ellen Griffiths

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City, Utah.

14. Informant: Joseph W. Pehrson

(Address) Pocatello, Idaho.

15. Filed 3/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Fracture of S Kull hit by bar at the Hands of Clifton Thornton Coroners Jury did not place responsibility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur W. Hall, Coroner ~~M. D.~~

3/29/30, 19..... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.

Date of Burial: 3/30/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69786

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5790

62-B

2. FULL NAME Charles Vivan. Waltman

(a) Residence. No. 543 South Harrison Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 23. 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	--	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER Thomas J. Waltman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Lottie Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant James Waltman
(Address) 631 North Hayes Ave

15. Filed 3/27, 1930 J. M. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26. 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1930, to Mar. 26, 1930
that I last saw him alive on Mar. 25, 1930
and that death occurred, on the date stated above, at 9.55 A. m.
The CAUSE OF DEATH* was as follows:
Hodgkins Disease
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct. 4-8, 1929.
Was there an autopsy? no
What test confirmed diagnosis? Exam. Excised gland.
(Signed) H. H. Lughart M. D.
Mar. 27, 1930 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountian View Cemetery	Mar 28. 1930
20. Undertaker	Address
Hall Mrotuary	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69781

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Brothers Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5789

44

2. FULL NAME Clara Marinda Mc Connel

(a) Residence. No. Albion Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of P. P. McConnel

6. DATE OF BIRTH (month, day and year) January 22. 1894

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	2	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hanisburg
(State or country) Nebraska

PARENTS

10. NAME OF FATHER Will Gibson
11. BIRTHPLACE OF FATHER (city or town) Lincoln
(State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Bertha Bray
13. BIRTHPLACE OF MOTHER (city or town) Lincoln
(State or Country) Neb

14. Informant P. P. McConnel
(Address) Albion Idaho

15. Filed 3/25, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25. 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1930, to Mar 25, 1930
that I last saw her alive on Mar 25, 1930
and that death occurred, on the date stated above, at 5:40 p m.
The CAUSE OF DEATH* was as follows:
Cancer of Liver

(duration) yrs. 3 mos. — ds.
CONTRIBUTORY (Secondary) Cancer of Left Breast (duration) 1 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yrs
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) [signature], M. D.
3/25, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Idaho	Mar 27 1930
20. Undertaker	Address
Arthur W. Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69782

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5788

(No. St Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

88a

2. FULL NAME Gus Bertsch

(a) Residence. No. Arco Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6. DATE OF BIRTH (month, day and year) Jan 23-1865

7. AGE Years 65 Months 2 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Probate Judge

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Henry Bertsch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Katherine Aldous

(Address) Salmon Idaho

15. Filed 3/29, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 25th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5, 1930, to Mar. 25, 1930

that I last saw him alive on Mar. 24, 1930

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (aortic regurgitation)

myocarditis

(duration) Several years. yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatoid Arthritis

(duration) 40 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) H. H. Hughart M. D.

3/29, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View

Date of Burial Mar 28 1930

20. Undertaker Schumacher & Neasley

Address City

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69783

Local Registrar's No. 5787

Registration District No. 28

Primary Registration District No. 2161

PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Lynn Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephine Ogeda

(a) Residence. No. 318 N 1st ave St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 9th 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	10	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER Sylvania

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sylvania

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Frolin Ogeda

(Address) 318 N 1st Pocatello Ida

15. Filed 3/29, 1930. J. H. Gaunt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1930, to Mar 24, 1930

that I last saw her alive on Mar 24, 1930

and that death occurred, on the date stated above, at 3 30 a.m.

The ~~CAUSE OF DEATH~~* was as follows:

Tuberculosis Lungs

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cholelithiasis

(duration) 1 yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phy Exam

(Signed) J. H. Gaunt, M. D.

3/28/30 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	3/25 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69784

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5786
(No. 535 South Ninth Ave. Poca. Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Oliver Jenkins Ellis

(a) Residence. No. 535 South Ninth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Elliott

6. DATE OF BIRTH (month, day and year) Sept. 11, 1899.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	6	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Oil Driller
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Logan, Utah.

PARENTS

10. NAME OF FATHER James H. Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan, Utah.
12. MAIDEN NAME OF MOTHER Eliza Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Ernest Ellis
(Address) Pocatello, Idaho.

15. Filed 3/21, 1930. J. W. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1930, to Mar. 19, 1930, that I last saw him alive on Mar. 19 1930 and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:
Parenchymatous nephritis
unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Intercostals of spine
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) H. B. Hughart, M. D.
3/21/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	3/23/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69785

RECEIVED APR 11 1930

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No.
Primary Registration District No.
Local Registrar's No. 143

(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Clayton

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 21, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
				2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Arthur W Clayton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Iris Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant William W. Clayton
(Address)

15. Filed 3-25, 1930 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1930, to Mar 21, 1930
that I last saw him alive on Mar 21, 1930
and that death occurred, on the date stated above, at 3 0. m.
The CAUSE OF DEATH* was as follows:
Premature birth — about 7 mos along. Cause Unknown
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Findings

(Signed) C O Swan M. D.
3/22, 1930 (Address) Paris Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paris Idaho	3-22 1930
20. Undertaker	Address
D. C. Rich	Paris Ida

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69786

Registration District No. 53
Primary Registration District No.
Local Registrar's No. 146

PLACE OF DEATH
County of Bear Lake
City of Bloomington
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Vernon Nard Painter

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Oct 8, 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Geo W. Painter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Deltha Thornock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Geo W. Painter
(Address) Bloomington Idaho

15. Filed March 30, 1930 Mrs J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1930 to Mar 25, 1930
that I last saw him alive on Mar 25, 1930
and that death occurred, on the date stated above, at 11.55 P. m.
The CAUSE OF DEATH* was as follows:
Erympelas. Migrans
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Pneumonia, Lobar
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Moore M. D.
3/26, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	3-28 1930
20. Undertaker	Address
John P. Hulsey	Bloomington Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

PLACE OF DEATH

County of Bear Lake

City of Fish Haven

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 55

Primary Registration District No. 2134

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69787

Local Registrar's No. 55

100 A

2. FULL NAME Nelda Alice Nelson

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 24 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	11	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER L R Nelson

11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)

12. MAIDEN NAME OF MOTHER Susie Loveland

13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant L R Nelson

(Address) Fish Haven Idaho

15. Filed Mar 1930 Hannah J. Nelson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from Feb 19, 1930, to Feb 20, 1930

that I last saw her alive on Feb 20, 1930

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
following Measles

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Measles

(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C O Myers M. D.

2/24, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Fish Haven	

20. Undertaker	Address
Shirley	Fish Haven Id.

RECE[illegible] APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69788

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 9

(No.) 142
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ed Morgan

(a) Residence. No. St Maries Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About Years 50 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Timber Workman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: John Mann
(Address) St Maries Ida

15. Filed March 31, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: accidentally drowned

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. G. Espe Coroner, M. D.
3-31, 1930 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida | Date of Burial: April 3 1930

20. Undertaker: Geo E Mitchell | Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69789

Local Registrar's No. 8

PLACE OF DEATH
County of Benewah
City of Fernwood

Registration District No. 22
Primary Registration District No. 2049

(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Robert White

(a) Residence. No. Fernwood Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
~~or~~ WIFE of Catherine White

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	9	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Lumbering
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Chas R White
(Address) Fernwood Ida

15. Filed March 31, 1930. Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 3-28, 1930
that I last saw him alive on 3-28, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows: Suicide committed by shooting with a 38 Cal revolver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?
(Signed) G G Estes, M. D.
3-29, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Coeur d' Alene Ida	3/31 1930
20. Undertaker	Address
Geo E Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69796

PLACE OF DEATH

County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Gates Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

41

2. FULL NAME Dora Stevens

(a) Residence. No. 413 S Second St. St Maries, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Jeremiah Stevens

6. DATE OF BIRTH (month, day and year) Jan. 18, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	2	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bryan Ohio

PARENTS

10. NAME OF FATHER Judson Benn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER ~~Nancy~~ Nancy Gilbert

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Ezra A Stevens
(Address) Othello, Wash

15. Filed March 25, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15-29, to 3-23, 1930
that I last saw her alive on 3-23, 1930
and that death occurred, on the date stated above, at 3 9 m.
The CAUSE OF DEATH* was as follows:

Toxaemia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) adhesions of bowels & common bile duct following removal of gall bladder
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1924-1925
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G Gillespie, M. D.
3-23, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	March 26 1930
20. Undertaker	Address
Geo Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 8 19

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
69791

1 PLACE OF DEATH
County Bonneville State Ida. Registered No.
Township or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susan Antelope 101 B

(a) Residence. No. St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis Antelope

6 DATE OF BIRTH (month, day, and year) Mch 2 - 1857

7 AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
73		22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) Round Valley
(State or country)

PARENTS

10 NAME OF FATHER Patrick Antelope
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Round Valley Reservation
12 MAIDEN NAME OF MOTHER Marie Fraser
13 BIRTHPLACE OF MOTHER (city or town) Round Valley Reservation
(State or country)

14 Informant Rosie Marshall
(Address) Dubois, Idaho

15 Filed March 26 1930 John Post
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 20, 1930, to Mch 25, 1930, that I last saw h alive on Mch 20, 1930, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.

3/26 1930 (Address) Dubois Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Dubois Ida	3/27 1930
20 UNDERTAKER Louis Michel	ADDRESS Dubois Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

F—209 d
V. S. No. 98

RECEIVED APR 8 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

69792

1 PLACE OF DEATH
County Bonneville State Idaho Registered No.
Township or Village or
City Dr Smet No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME M. M. Kutch

10180

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Kinebat

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 79 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10 NAME OF FATHER: Wm Kutch
11 BIRTHPLACE OF FATHER (city or town) (State or country): Iowa
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Albie Kutch
(Address) De Smet, Idaho

15 Filed March 24, 1930 John Post
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 23, 1930, to March 23, 1930
that I last saw ~~him~~ alive on March 23, 1930
and that death occurred, on the date stated above, at 11 30 P m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Influenza
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of no
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J. A. Nelson M. D.
3/24 1930 (Address) Tekoa, Wn

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Formington
DATE OF BURIAL: 3/26 1930

20 UNDERTAKER: C. L. Schulerud
ADDRESS: Tekoa Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—209 d
V. S. No. 98

11—8184 GOVERNMENT PRINTING OFFICE

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69794

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 48

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Ardon J. Plaza

(a) Residence. No. South Fisher St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 25 1930

7. AGE Years Months 2 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER Frank R. Plaza
11. BIRTHPLACE OF FATHER (city or town) (State or Country) California
12. MAIDEN NAME OF MOTHER Lottie I. John
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Portage Utah

14. Informant H. T. John
(Address) Blackfoot Idaho

15. Filed Mar 28, 1930 Mrs Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930, to Mar 27, 1930 that I last saw him alive on Mar 20, 1930 and that death occurred, on the date stated above, at ~~mo~~ 6 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W W Beck, M. D.

3/28, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Portage Utah | Date of Burial 19

20. Undertaker E T Peck | Address Blackfoot Ida

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69795

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No. K)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

157

2. FULL NAME Ephriam Knowlton Hanks
(a) Residence No. Shelley Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Hanks

6. DATE OF BIRTH (month, day and year) May 18, 1865

7. AGE Years 64 Months 10 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Charleston Wash

PARENTS
10. NAME OF FATHER Ephriam K. Hanks
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cleveland Ohio
12. MAIDEN NAME OF MOTHER Sarah Capner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dayton Ny

14. Informant Frank Hanks
(Address) Shelley Idaho

15. Filed Mar 25 30 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch. 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 30, 1930, to Mch 24, 1930
that I last saw him alive on Mch. 24, 1930
and that death occurred, on the date stated above, at 5 20 PM
The CAUSE OF DEATH* was as follows:
Gangreen Lung
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Septicemia
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. R. Roberts, M. D.
Mch 25, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho — Date of Burial March 27 1930

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instruction on back of certificate.

APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69796

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. 340 E. Alice St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

2. FULL NAME Maud R. Patten

(a) Residence. No. East Alice Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of W. N. Patten

6. DATE OF BIRTH (month, day and year) Dec. 6, 1883

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	3	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10. NAME OF FATHER Geo. W. Kidd

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Mary E. Marrow

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant W. N. Patten
(Address) Blackfoot. Ida.

15. Filed Mar. 23. 1930 Wm Mullen E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 22. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Mar 22, 1930
that I last saw her alive on Mar 21, 1930
and that death occurred, on the date stated above, at 4:25 m.
The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No (Findings)
What test confirmed diagnosis? Symptoms
(Signed) Walbeck, M. D.
3-23-30, 19 (Blackfoot. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moore Idaho	3-24-30, 19

20. Undertaker Modern Mortuary Address Blackfoot.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69797

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 45

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 a

2. FULL NAME Bettie Elnor Larson Wigand

(a) Residence. No. 288 No. Shilling Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 26 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~(or) WIFE of~~ HUSBAND of: J. L. Wigand

6. DATE OF BIRTH (month, day and year) Jan 25, 1867

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	1	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Morgan County, Utah

PARENTS

10. NAME OF FATHER: Nilso Larson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Willie Sweden

12. MAIDEN NAME OF MOTHER: Bengta Flygare

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Swedola Sweden

14. Informant: J. L. Wigand
(Address) Blackfoot

15. Filed Mar 23, 1930 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to Mar. 19, 1930 that I last saw her alive on Mar. 19, 1930 and that death occurred, on the date stated above, at 6:55 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ... yrs. ... mos. 5 ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) W. K. Eagan Dr., M. D.

Mar. 21, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery

Date of Burial: Mar. 23, 1930

20. Undertaker: E. J. Peck

Address: Blackfoot

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69798

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2191

Local Registrar's No. 44.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

.10 0 a

2. FULL NAME Bobby B. Eaton

(a) Residence. No. ..... Shelley Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29, 1929

7. AGE — Years: — Months: 7 — Days: 20 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Shelley Idaho

PARENTS

10. NAME OF FATHER: J. E. Eaton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Weyanak Utah
12. MAIDEN NAME OF MOTHER: Alice Bertha Starkie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah

14. Informant: J. E. Eaton
(Address): Shelley Idaho

15. Filed Mar 21, 1930 — Mrs Walter E. Patrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-14-, 1930, to 3-19, 1930
that I last saw h[illegible] alive on 3-19-, 1930
and that death occurred, on the date stated above, at 8.30 a m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Rickets.

(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) Edwin Critle, M. D.
3-21-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley Idaho — Date of Burial: Mar 21 1930

20. Undertaker: Clark A. Ward — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69799

PLACE OF DEATH

County of Bingham
City of Blackfoot.
Registration District No. 127
Primary Registration District No. 2194.
Local Registrar's No. 43
(No. 1 Mile North of City Sugar Co. grounds.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Hernandez
(a) Residence. No. Sugar Factory St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 90 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Mexican	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May, 1900

7. AGE	Years	Months	Days	If LESS than 1 day,
	30			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Jesus Hernandez
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Elizabeth Cortez
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico.

14. Informant Jesus Hernandez
(Address) Blackfoot, Ida.

15. Filed Mar. 19, 1930 Mr Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 18. 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar 18, 1930
that I last saw him alive on Mar 18, 1930
and that death occurred, on the date stated above, at 9:00 P m.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Mitral Insufficiency
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic endocarditis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) W. W. Beck, M. D.
Mar. 19, 1930 (Address) Blackfoot. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	3-20-30 19

20. Undertaker	Address
Modern Mortuary	Blackfoot. Ida

FORM V. S. No. 5-25 M. 1-19. RECEIVED APR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

File No. 69800

Registered No. 42

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dona Jane Adamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Woodville, Idaho

10. NAME OF FATHER: Kenith W. Adamson

11. BIRTHPLACE OF FATHER (State or Country): Shelley

12. MAIDEN NAME OF MOTHER: Bertha Huntsman

13. BIRTHPLACE OF MOTHER (State or Country): Woodville

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara Christensen

(Address) Idaho Falls R#6

15. Filed Mar. 14 1930 Mrs Walter E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1930 (Year) 1000a

17. I HEREBY CERTIFY, That I attended deceased from March 9 1930, to March 12 1930 that I last saw her alive on 12 1930 and that death occurred on the date stated above, at 9 00 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia + Acute Indigestion

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Indigestion

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Edwin Cutler M. D.

Mar 13 1930 (Address) Shelley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shelley

DATE OF BURIAL: 14 1930

20. UNDERTAKER: None

ADDRESS: —

Parents

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69801

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 41

110

2. FULL NAME GOOTFRIED EMIL BEUTEL

(a) Residence. No. ..... St. Boise, Ida. R-4
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. 1½ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Nellie Beutel,

6. DATE OF BIRTH (month, day and year)

7. AGE: 66 Years | Months: 9 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: Gottfried E Beutel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Agrest Rheemer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Noel Gebauer
(Address) Blackfoot, Ida.

15. Filed Mar. 14, 1930 Max Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 13th, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar. 11th 1930, 19 to Mar 13, 1930, 19
that I last saw him alive on March 13th, 1930, 19
and that death occurred, on the date stated above, at 8:30A m.
The CAUSE OF DEATH* was as follows: Starvation from obstruction of esophagus
Cause of obstruction unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Dont know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams, M. D.
Mar 13 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Idaho | Date of Burial: on arrival 19

20. Undertaker: E J Peck | Address: Blackfoot

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69802

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

42

2. FULL NAME Mary E. Rumble
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: -- William S. Rumble

6. DATE OF BIRTH (month, day and year): Feb. 20, 1860

7. AGE: Years 70 | Months | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Verginia

PARENTS
10. NAME OF FATHER: Perry Robbins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Verginia
12. MAIDEN NAME OF MOTHER: Catherine Bear
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Verginia

14. Informant: W. B. Rumble
(Address) Firth R. F. D. #1

15. Filed Mar 13, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 11. 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to March. 11, 1930 that I last saw her alive on March 11, 1930 and that death occurred, on the date stated above, at 11:30A m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
& Cancer of Bladder & intestines
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? --
Did an operation precede death? No Date of --
Was there an autopsy? No
What test confirmed diagnosis? Phsical findings
(Signed) J. O. Hampton M. D.
Mar. 13, 1930 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery
Date of Burial: Mar. 13, 1930

20. Undertaker: E. J. Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69803

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 12
Primary Registration District No. 3194
Local Registrar's No. 39
(No. Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74

2. FULL NAME Don Loretta

(a) Residence. No. Mexico St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Mexican	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Harold Corwin
(Address) Blackfoot, Idaho

15. Filed Mar. 12, 1930 Malen E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8th, 1928, to March 11, 1930
that I last saw him alive on March 11, 1930
and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Hullinger M. D.
Mar 11, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation or Removal~~	Date of Burial
Asylum Cem.	Mar 12 1930
20. Undertaker acting Marion Clark	Address Blackfoot.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69804

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

88B

2. FULL NAME Mary C. Munson
(a) Residence. No. Moreland St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Munson

6. DATE OF BIRTH (month, day and year) Oct. 28 - 1844

7. AGE: Years 85, Months 5, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Jas. Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Marie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant C. L. Munson
(Address) Moreland Ida

15. Filed Mar 13, 1930 Wm Valerie E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 11 - 1930 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to March 11, 1930
that I last saw her alive on March 10, 1930
and that death occurred, on the date stated above, at 1:00 A. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) 10 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) W W Beck, M. D.
3/12, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moreland Ida
Date of Burial: 3-13-1930

20. Undertaker: Modern Mortuary
Address: Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69805

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

12P

2. FULL NAME Duraine Carroll Anderson

(a) Residence. No. RD# 3 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 3, 1924

7. AGE 5 Years | Months 10 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — none
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Blackfoot, Ida

PARENTS
10. NAME OF FATHER Irving P. Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mink Creek Idaho
12. MAIDEN NAME OF MOTHER Goldie Myrtle Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garden City Utah

14. Informant Irving P. Anderson.
(Address) Blackfoot N.R.I.

15. Filed Mar 6, 1930 Wm Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to March 6, 1930
that I last saw him alive on March 6, 1930
and that death occurred, on the date stated above, at 12:10 P m.
The CAUSE OF DEATH* was as follows:

Peritonitis (General)
(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza
(duration) — yrs. — mos. 12 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck M. D.
3/6, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Gem City Cemetery | Date of Burial 3-8 1930

20. Undertaker E J Peck | Address Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69806

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 3194
Local Registrar's No. 36

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Mary Arvish
(a) Residence. No. Blackfoot. Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Arvish

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 70, Months 8, Days 27. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Berlin Germany

PARENTS

10. NAME OF FATHER: Henry Kurz
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Berlin Germany
12. MAIDEN NAME OF MOTHER: Kathrine Neckont.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Berlin Germany

14. Informant: Henry Arvish
(Address) Blackfoot Idaho

15. Filed Mar 11, 1930 Mrs Helen E. Cabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) — 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 — 1, 1930, to 3 — 8, 1930
that I last saw her alive on 3 — 8, 1930
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis & chronic nephritis
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) J. D. Hamilton M. D.
3 — 10, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Groom City Cemetery
Date of Burial: 3 — 11 1930

20. Undertaker: E J Peck
Address: Blackfoot

APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69807

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 31

2. FULL NAME JULIA COLLINS

(a) Residence. No. ... St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	WIDOW

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	70			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) IRELAND

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---
12. MAIDEN NAME OF MOTHER ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Hazel Killian Att.
(Address) Blackfoot, Ida.

15. Filed Mar. 5, 1930 Mabel E. Adams Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, to Mar 4th 1930,
that I last saw her alive on Mar 4th 1930,
and that death occurred, on the date stated above, at 5:50 P m.
The CAUSE OF DEATH* was as follows:

General Paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams, M. D.
Mar 4th, 1930 (Address) Blackfoot I

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cem	3-5 1930
20. Undertaker	Address
Marion Clark	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69808

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 34
(No. Mrs Trance Hosp. West Judicial St
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Albert Meek Vaughn
(a) Residence. No. Blackfoot St. 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Jan. 3 - 1880
7. AGE Years 50 Months 2 Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer not employed
9. BIRTHPLACE (city or town) (State or country) Perry Idaho

PARENTS
10. NAME OF FATHER James H. Vaughn.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clinton County Missouri
12. MAIDEN NAME OF MOTHER Mary Annie Robbins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs R. E. Hansen
(Address) P.O. Box 297 Blackfoot Id.
15. Filed Mar 6, 1930 Mr Peter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 4, 1930
that I last saw he we alive on Mar 3, 1930
and that death occurred, on the date stated above, at 2:30 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia - lobar
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Asthma
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) W. E. Patrie, M. D.
Mar 6, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grove City Cemetery
Date of Burial 3-7 1930
20. Undertaker E J Peck
Address Blackfoot

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 8 1930

PLACE OF DEATH

County of Bingham

City of Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

(No. Beck Hospital - Eccles Bldg.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69809

Local Registrar's No. 33

161a

2. FULL NAME Marie Ann Willmore

(a) Residence. No. ~~Black~~ Pocotello St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1st 1930

7. AGE Years Months Days If LESS than 1 day, 1 hrs. or 35 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Ida.

PARENTS

10. NAME OF FATHER John Willmore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rexburg Ida

12. MAIDEN NAME OF MOTHER Ruby Lock.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma.

14. Informant Carl Wilmore
(Address) Eccles Hotel Room 233.

15. Filed Mar 4, 1930 McPhaline Catrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to Mar 1, 1930 that I last saw her alive on Mar 1, 1930 and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6th mo
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother Fell
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Beck, M. D.

3/1, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Grove City Cemetery — Date of Burial: Mar. 4 1930

20. Undertaker: E. Leach — Address: Blackfoot

RECEIVED APR 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69816

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bingham
City of Aberdeen, Idaho

Registration District No. 116
Primary Registration District No. 2195
(No.)

Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

101a

2. FULL NAME Edwin P. Ruff

(a) Residence. No. 10 miles north of Am Falls, St. Aberdeen, Idaho
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 20th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer G. Ruff.

9 BIRTHPLACE (city or town) (State or country) N.D.

PARENTS

10 NAME OF FATHER G. Ruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Marry Knodal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Gottfried Ruff
(Address) Aberdeen Idaho

15 Filed 3/22, 1930 M McCutcheon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 22nd (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from march 10, 1930, to March 22, 1930, that I last saw h- alive on march 22, 1930 and that death occurred, on the date stated above, at 7A. m.

The CAUSE OF DEATH* was as follows:

Solar Prominence

(duration) ... yrs. ... mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M McCutcheon, M. D.
3/22/, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Am Falls, Idaho — Date of Burial: 3-24-1930

20. Undertaker: A W Davis — Address: American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69811

PLACE OF DEATH
County of Buchanan
City of Sterling

Registration District No. 116
Primary Registration District No. 2195
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

161B

2. FULL NAME Earl Foster Randall

(a) Residence. No. Sterling, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mch 4 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sterling, Ida.

PARENTS

10. NAME OF FATHER Foster Randall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Groveland Idaho
12. MAIDEN NAME OF MOTHER Abbie Caldwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Thomas Idaho

14. Informant Foster Randall
(Address) Sterling, Ida

15. Filed 3/14, 1930. M. C. Markman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 13, 1930
that I last saw h[illegible] alive on March 13, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage —
Birth injury
(duration) yrs. mos. 9 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) M. C. Markman, M. D.
3/14, 1930 (Address) Hansen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Ida	Mch 15 1930
20. Undertaker Friend	Address —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69812

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

162

2. FULL NAME Raymond Gordon Hayter
(a) Residence. No. Aberdeen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Feb. 19, 1930

7. AGE Years Months Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) American Falls, Ida
(State or country)

PARENTS

10. NAME OF FATHER Glen Gordon Hayter
11. BIRTHPLACE OF FATHER (city or town) Prince Edward Island, Canada
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Margaret Hoffer
13. BIRTHPLACE OF MOTHER (city or town) Hebron, N. Dak.
(State or Country)

14. Informant Mary Hayter
(Address) Aberdeen, Idaho

15. Filed 3/11, 1930 McCracken Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to March 10, 1930
that I last saw her alive on March 9, 1930
and that death occurred, on the date stated above, at 5:30 a. m.
The CAUSE OF DEATH* was as follows:
Pemphigus Neonatorum
(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) McCracken, M. D.
3/10, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Aberdeen Ida
Date of Burial 3/11 1930

20. Undertaker [illegible]
Address

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6981 3

Registration District No. 57
Primary Registration District No. 2022
(No.)
Local Registrar's No. 13

PLACE OF DEATH
County of Blaine
City of Hailey

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adolph Karl Koenig

(a) Residence. No. / St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Austrian	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Oct 29-1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	5	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Karlsdorf, Mahren Austria

PARENTS
10. NAME OF FATHER X
11. BIRTHPLACE OF FATHER (city or town) (State or Country) X
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X

14. Informant Robert H. Wright-M.D.
(Address)

15. Filed 4-1, 1930 R. H. Wright-
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25, 1930, to 3-27, 1930
that I last saw him alive on 3-27, 1930
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Underground Miner
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Robert H. Wright- M. D.
3/27, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey	Mar 30 1930
20. Undertaker	Address
Harris Bros	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69814

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

48 B

2. FULL NAME John Young
(a) Residence. No. Carey, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 14 - 1866

7. AGE: Aug Years 63 Months 7 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Clintonville Wis

PARENTS
10. NAME OF FATHER: Edward Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country): —
12. MAIDEN NAME OF MOTHER: Diadema — Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: Hospital Record -
(Address)

15. Filed 4 - 1, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to March 20, 1930
that I last saw him alive on March 20, 1930
and that death occurred, on the date stated above, at 5.30 a m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Anasarca
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Carey, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
3/20, 1930 (Address) E. W. [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey
Date of Burial: Mar 20 1930

20. Undertaker: Harris & Amos
Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69815

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Esther Ann Werry

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Werry.

6. DATE OF BIRTH (month, day and year) June 1 - 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cornwall - England

PARENTS

10. NAME OF FATHER Ralph Sandra
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Harvey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Beryl Werry & Esther Breazeal
(Address) Bellevue Ida

15. Filed 4 - 1, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 - 25, 1930, to 3 - 9, 1930
that I last saw h[illegible] alive on 3 - 9, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH*/was as follows:
Myocarditis
(duration) 2 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Robert H. Wright - M. D.
3 - 10, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Ida	Mar 11 1930

20. Undertaker	Address
Harris & Amor	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69816

Local Registrar's No. 4

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Albert Edward Welberry

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fay Hill Welberry

6 DATE OF BIRTH (month, day and year) July 25, 1876

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Swineshead
(State or country) England

PARENTS

10 NAME OF FATHER John Welberry

11 BIRTHPLACE OF FATHER (city or town) Swineshead
(State or country) England

12 MAIDEN NAME OF MOTHER Howden

13 BIRTHPLACE OF MOTHER (city or town) Swineshead
(State or country) England

14 Informant H A Spacht

(Address) Priest River Idaho

15 Filed Mar. 17, 1930 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 15 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1929, to March 15, 1930, that I last saw h.im alive on March 17, 1930, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) H. A. Spacht M. D.

Mar 16 1930 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmens Cemetery	Mar. 19 1930
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 7 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69817

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead instead of street and number.) 161 15

2. FULL NAME Lois Alma Orr

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 26, 1930

7 AGE — Years | Months | Days: 3 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Priest River, Idaho

PARENTS

10 NAME OF FATHER: Roland R. Orr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mason County Mich.

12 MAIDEN NAME OF MOTHER: Marjorie D. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ludington, Mich.

14 Informant: Roland R. Orr
(Address): Priest River Ida.

15 Filed Mar 2, 1930 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 1, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 1, 1930, that I last saw her alive on March 1, 1930, and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:
Birth injury - Cephalic paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Difficult Labor.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at place of death.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) R. E. Wessa M. D.
Mar 2, 1930 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Mar 2, 1930
20. Undertaker: Moon Mortuary	Address: Priest River, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69818

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 80
Primary Registration District No. 1157
Local Registrar's No. 5

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Marie Anderson

(a) Residence. No. Hope Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Anderson

6. DATE OF BIRTH (month, day and year) Oct 9 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	4	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Halvdan Anderson
(Address) Hope Idaho

15. Filed March 1st, 1930 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb - 24, 1930 to Feb - 28, 1930
that I last saw her alive on Feb - 24, 1930
and that death occurred, on the date stated above, at 10:15 P M m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd Gillespie M. D.
3-1, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hope Cemetery	Mar 2 1930

20. Undertaker	Address
Turnbull Co	Sandpoint

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69826

PLACE OF DEATH

County of Bonner

City of Algoma

Registration District No. 78

Primary Registration District No. 2155

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

74a

2. FULL NAME Fred Hannerman

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Abbie Hannerman

6. DATE OF BIRTH (month, day and year) July 14, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Fred Hannerman, Jr.

(Address) Algoma, Idaho.

15. Filed March 27, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 23, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to March 23, 1930

that I last saw him alive on March 23, 1930

and that death occurred, on the date stated above, at 9:20p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with Hypertension (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.

March 27, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	March 27 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69822

Local Registrar's No. 29

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Oscar Louis Peavey

(a) Residence. No. 224 Main St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Estelle Peavey

6. DATE OF BIRTH (month, day and year) Oct. 29, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	4	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work General Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Humbird Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Lincoln Center Maine

PARENTS

10. NAME OF FATHER Frank Peavey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E.E.Boies

(Address) Sandpoint, Idaho.

15. Filed March 22 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 19th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 6:45 p m.

The CAUSE OF DEATH* was as follows:

Epithelioma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Dec 4-1929

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) O.F.Page, M. D.

March 22, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Mar.22, 1930
20. Undertaker	**Address**
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69823

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

101a

2. FULL NAME William Arthur Kalk

(a) Residence. No. R.F.D. 1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26, 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	11m	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Albert Kalk

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Mary Gordon

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Denmark

14. Informant Albert Kalk
(Address) Sandpoint, Idaho.

15. Filed March 15, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 16, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 8, 1930, to Mch 16, 1930
that I last saw him alive on Mch 15, 1930
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.
Mch. 17, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Mar. 18 1930
20. Undertaker	**Address**
MOON MORTUARY	SANDPOINT, IDA

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69824

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 27

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

41b

2. FULL NAME George W. Ulrich

(a) Residence. No. 422 Lake Street St.
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorded

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Ulrich

6. DATE OF BIRTH (month, day and year) January 21, 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	1	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eau Claire Wisconsin

PARENTS

10. NAME OF FATHER William F. Ulrich

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Odelia Fremont

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Len Ulrich

(Address) Sandpoint, Idaho.

15. Filed Mar 16, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11, 1930, to Mar 13, 1930

that I last saw h alive on Mar 13, 1930

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows: Chr Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) R Sims, M. D.

Mar. 15, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Mar. 16 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69825

PLACE OF DEATH

County of BONNER

City of SANDPOINT

Registration District No. 78

Primary Registration District No. 2155

(No. Main and Division Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

47

2. FULL NAME Lena May Cooper

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Cooper

6. DATE OF BIRTH (month, day and year) July 3, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	8	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Henry C. Chipman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Woolworth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Moon Mortuary

(Address) Sandpoint, Idaho.

15. Filed Mar. 14, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 12, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar-12, 1930, to Mar-14, 1930

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 2:10 p m.

The CAUSE OF DEATH* was as follows:

Multiple Carcinoma involving breast

(duration) 9 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Floyd G. Wendle, M. D.

March 14, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Mar. 15 1930
20. Undertaker	Address
MOON MORTUARY	SANDPOINT, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69826

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. 222 Pine Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 25

49

2. FULL NAME Charles J. Rudine

(a) Residence. No. 319 Pine Street St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE — Years: 65 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer): Cedar Products
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: E.C.Helmholtz
(Address): Sandpoint, Idaho.

15. Filed Mar 4, 1930 — Viola Allen, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Mar 11, 1930
that I last saw him alive on Mar. 11, 1930
and that death occurred, on the date stated above, at 11 p.m.
The CAUSE OF DEATH* was as follows:
Carcinoma — upper right abdomen
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? X Ray
(Signed) C. F. Stackhouse, M. D.
3/13, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
PINECREST CEMETERY	Mar.14 1930
20. Undertaker	Address
MOON MORTUARY	SANDPOINT IDAHO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69827

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 24

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Samuel M. Moore

(a) Residence. No. 436 S Euclid ave St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Ann Moore

6. DATE OF BIRTH (month, day and year) Sept 30, 1850

7. AGE 79 Years 5 Months 1 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Macon Missouri

PARENTS

10. NAME OF FATHER Theodore Moore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Martha Roberts.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Mrs S. M. Moore
(Address) 436 S Euclid ave, Sandpoint, Ida.

15. Filed Mar 4, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1928, to Mar 2, 1930

that I last saw him alive on Mar. 1, 1930

and that death occurred, on the date stated above, at 6:45 A.m.

The CAUSE OF DEATH* was as follows:
Carcinoma lower abdomen

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Stacchouse, M. D.

3/4/30, 19 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: Mar. 4, 1930

20. Undertaker: Moon Mortuary — Address: Sandpoint, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69828

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

66

2. FULL NAME C. E. Wood (Clinton Adelbert Wood)

(a) Residence. No. Sandpoint, Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Wood

6. DATE OF BIRTH (month, day and year) Dec. 31, 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~About 55 yrs~~ 66	2	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cascade Township Michigan

PARENTS

10. NAME OF FATHER W. Roy A. Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York State

12. MAIDEN NAME OF MOTHER Phoebe Reynolds

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York State

14. Informant Mrs. J. A. Adams or E.T. Chapple
(Address) Sandpoint, Idaho 50 Carlton Ave SE Grand Rapids Michigan

15. Filed March 3, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from did not attend 19 to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:
Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd E. Keeler County Phys. M.D.
3-3, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grand Rapids, Mich	Shipping Mar. 3, 1930

20. Undertaker	Address
Moon Mortuary	Sandpoint Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC'D MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69829

PLACE OF DEATH
County of Bonneville
City of Idaho Falls,
Registration District No. 73
Primary Registration District No. 2107
Local Registrar's No. 44
(No. Idaho Falls L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Genieve Harriet Clark.

(a) Residence. No. ..... St. Rigby, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a. If married, widowed, or divorced
(or) WIFE of C. W. Clark.

6. DATE OF BIRTH (month, day and year) Jan. 26, 1888

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	0	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER George A. Graham.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Philinda Cole.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant C. W. Clark
(Address) Rigby, Idaho.

15. Filed Mar 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 19..., to Feb 14, 19...
that I last saw her alive on Feb. 14, 19...
and that death occurred, on the date stated above, at 3:15 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Chr. Hypertension & arteriosclerosis (duration) 7 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. R. Nye, M. D.
3/ , 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	2/18/30 19

20. Undertaker [signature] Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69830

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

107

2. FULL NAME Harriett Nelson
(a) Residence. No. 319 West 16th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jos L. Nelson

6. DATE OF BIRTH (month, day and year) April 19, 1909

7. AGE: Years 20 | Months 10 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ucon, Idaho

PARENTS
10. NAME OF FATHER: A. H. Tracy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden, Utah
12. MAIDEN NAME OF MOTHER: Hannah Ritchie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden, Utah

14. Informant: Jos. L. Nelson
(Address) Idaho Falls, Idaho

15. Filed Mar 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 27, 1930
that I last saw her alive on Feb 27, 1930
and that death occurred, on the date stated above, at 9-8 P. m.
The CAUSE OF DEATH* was as follows:
Empyema
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary): Pneumonia Lobar
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes No Date of Feb 27
Was there an autopsy?
What test confirmed diagnosis? Xray & surgery
(Signed) [signature], M. D.
Mar 1, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho | Date of Burial: March 3 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69831

PLACE OF DEATH.
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

2. FULL NAME Henry Bair
(a) Residence. No. Nibley, Utah St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Henry Bair

6. DATE OF BIRTH (month, day and year) Mar 11, 1861

7. AGE Years 68 Months 3 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Providence, Utah

PARENTS
10. NAME OF FATHER Henry Bair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Erwin Bair
(Address) Idaho Falls Rt #3

15. Filed Feb 26, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to Feb 25, 1930
that I last saw him alive on Feb 24 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Acute Streptococcic infection beginning in wound left forearm
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H Ray Hatch M. D.
Feb 25, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Millville, Utah
Date of Burial Feb 28 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 19 1930

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2 1 4 0

(No. L.D.S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 60832

Local Registrar's No. 431

2. FULL NAME Harvey Hyrum Hansen

(a) Residence. No. 477 12th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Jan. 3, 1918

7. AGE	Years	Months	Days	If LESS than 1 day,
	12		24	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moody Creek, Idaho

PARENTS

10. NAME OF FATHER Hyrum Hansen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Teton City, Idaho

12. MAIDEN NAME OF MOTHER Irene Searle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Basin Utah

14. Informant Mr. Hyrum Hansen

(Address) Idaho Falls, Idaho

15. Filed Feb 26, 1930 C. A. Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb 23, 1930

that I last saw him alive on Feb 23, 1930

and that death occurred, on the date stated above, at 3. A M m.

The CAUSE OF DEATH* was as follows:

Acute and Chronic Rheumatic endocarditis and myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. Ray Hatch, M. D.

Feb 26, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Teton City, Idaho — Date of Burial: Feb 27 1930

20. Undertaker: Jack A. Hood — Address: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69833

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21V-0

Local Registrar's No. 40

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Donald Williams Rainsden

(a) Residence. No. 457 Broadway St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6. DATE OF BIRTH (month, day and year): Feb. 18-1930

7. AGE: Years 0, Months 0, Days 6. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Ida.

PARENTS

10. NAME OF FATHER: J. E. Rainsden

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho Falls Ida.

12. MAIDEN NAME OF MOTHER: Louise McCabe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pittsburg Penna

14. Informant: J. E. Rainsden
(Address): Idaho Falls Ida.

15. Filed Feb 24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to Feb 24, 1930

that I last saw him alive on Feb 24, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Stenosis mon[illegible]

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) [signature], M. D.

Feb 24, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Date of Burial Feb 25 1930

20. Undertaker: V. F. McHan Address Idaho Falls Ida

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69834

PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2170
Local Registrar's No. 39

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Augustus Miles

(a) Residence. No. 1 Mile N. of Idaho Falls.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Minnie A Miles

6. DATE OF BIRTH (month, day and year): Oct 22 1861

7. AGE: Years 68 | Months 4 | Days 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Memphis Tenn

PARENTS
10. NAME OF FATHER: Chas Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Mary Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Mrs Minnie A Miles
(Address) Idaho Falls Ida

15. Filed Mar 24, 1930 (Signature) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 22, 1930, that I last saw h~~im~~ alive on Feb 21, 1930, and that death occurred, on the date stated above, at 8 20 A. m.

The CAUSE OF DEATH* was as follows:

Emphysema
(duration) yrs. 1 mos. 7 ds.
CONTRIBUTORY (Secondary): Chronic Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Feb 25 1930

20. Undertaker: P. F. McHan | Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69836

PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 214-0

Local Registrar's No. 37

205-B

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Delphin Haskell

(a) Residence. No. 379 - 4 St. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 23, 1864

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65	4	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oskaloosa Iowa.

PARENTS

10. NAME OF FATHER Platt Ketcham

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York. N.Y.

12. MAIDEN NAME OF MOTHER Eunice Beers.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J. Le Lorey

(Address) Idaho Falls Ida.

15. Filed Feb 20, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw her alive on ....., 19.....

and that death occurred, on the date stated above, at 5454 m.

The CAUSE OF DEATH* was as follows:

Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) A. Christan scientist

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Dr. B. J. Allen L.C. M.D.

Feb 20, 1930 (Address) coroner Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Feb 23 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69837

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
(No. L D S Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

117

2. FULL NAME Jennie Lockyer
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. T. Lockyer

6. DATE OF BIRTH (month, day and year) Dec 30 1908

7. AGE: Years 21, Months 1, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Taylor Ida

PARENTS
10. NAME OF FATHER: F. A. Wadsworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hooper Utah ~~Taylor Idaho~~
12. MAIDEN NAME OF MOTHER: Lydia Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Hyrum Utah

14. Informant W. T. Lockyer
(Address) Idaho Falls Ida.

15. Filed Feb 19, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 18 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from Feb 12, 1930, to Feb 18, 1930
that I last saw her alive on ....., 19....
and that death occurred, on the date stated above, at 4.45 P m.
The CAUSE OF DEATH* was as follows:
Acute Appendicitis
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) General Peritonitis
..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Feb 12-1930
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth Idaho. Date of Burial: Dec 31 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69838

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 31

(No.) 111B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Frederick Law
(a) Residence. No. Firth, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Smith Law

6. DATE OF BIRTH (month, day and year) May 10, 1872

7. AGE Years 57 Months 9 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cedar Fort, Utah

PARENTS
10. NAME OF FATHER Isaac Law
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Hannah Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant A. F. Law
(Address) Firth Rt #1

15. Filed Feb 17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930 to Feb 15, 1930
that I last saw him alive on Feb 15, 1930
and that death occurred, on the date stated above, at 10-20 a m.
The CAUSE OF DEATH* was as follows:
Perforated Duodenal Ulcer
(duration) yrs. mos. 41 hours ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Shelley, Idaho
Did an operation precede death? Yes No Date of Feb 14
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley, Idaho
Date of Burial Feb 17 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69839

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 N-9
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

1HH

2. FULL NAME Bertha Marie Kelley

(a) Residence. No. Shelley, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Floyd Kelley

6. DATE OF BIRTH (month, day and year) May 26 1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	8		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fowler, Colorado

PARENTS

10. NAME OF FATHER B. Bendixsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Pauline Erickson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Floyd Kelley
(Address) Shelley, Idaho

15. Filed 2/13, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-9, 1930, to 2-10, 1930 that I last saw her alive on 2-10, 1930 and that death occurred, on the date stated above, at 4-10 m.

The CAUSE OF DEATH* was as follows: Secondary Hemorrhage - from Cervical Tear.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Large Child - Hard Labor 12 hrs

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Post-Mortem Vaginal Examination
(Signed) E. Cutler M. D.
2-11-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelley, Idaho	Feb. 14 1930

20. Undertaker Jack A. Woods Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69846

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 10 -0
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 53

24

2. FULL NAME Earl Hayes
(a) Residence. No. 262 - So Water St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) October 3, 1929
7. AGE Years Months 4 Days 8 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah

PARENTS
10. NAME OF FATHER J. H. Hayes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ammon, Idaho
12. MAIDEN NAME OF MOTHER Elizabeth Alstrom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelley, Idaho

14. Informant Mr. J. H. Hayes
(Address) Idaho Falls, Idaho

15. Filed 2/13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 11, 1930
that I last saw him alive on Feb 11, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Epi Cerebral Sp. Meningitis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Bronchial pneumonia
(duration) yrs. mos. ? ds.
18. Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal Puncture
(Signed) [signature], M. D.
2/12, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial February 13 1930
20. Undertaker Jack A. Wood
Address Idaho Falls.

RECEIVED APR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69841

PLACE OF DEATH
County of ~~Custer~~ Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129. Local Registrar's No. 19

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Walter Arthur Stockwin

(a) Residence. No. Arco (Usual place of abode.) St. Idaho
(If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	wht	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary D. Stockwin

6. DATE OF BIRTH (month, day and year) Apr. 12, 1860

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Alton, Ill.

PARENTS

10. NAME OF FATHER Thomas Stockwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Cynthia Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) Mary D. Stocking

15. Filed March 14, 1930. T. Sale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 14, 1930
that I last saw him alive on March 13, 1930
and that death occurred, on the date stated above, at 3 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute uremia

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chronic nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? ✓ What test confirmed diagnosis? laboratory

(Signed) L. R. Egbert, M. D.
March 14, 1930 (Address) Arco Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco, Idaho	Mar. 16 1930
20. Undertaker Theo. R. Garmin	Address Mackay Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69842

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129 Local Registrar's No. 20
(No.) 107
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel Dockhaw Remion
(a) Residence. No. Bernice Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Remion

6. DATE OF BIRTH (month, day and year) Feb. 14 - 1877

7. AGE Years 53 Months 1 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS
10. NAME OF FATHER Mr. Dockhaw ~~Unknown~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Hampshire
12. MAIDEN NAME OF MOTHER Myra
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New Hampshire

14. Informant (Address) Charles Remion

15. Filed April 11, 1930. T. P. Salt Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 9, 1930
that I last saw her alive on April 9 1930
and that death occurred, on the date stated above, at 1:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Edema of Lungs
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam
(Signed) J. R. Egbert M. D.
April 11, 1930 (Address) Arco Ida.

19. Place of Burial, Cremation, or Removal Arco
Date of Burial April 11 1930

20. Undertaker Theo R. Garnier
Address Arco

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69843

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 35
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

8803

2. FULL NAME Laura C. Barnes
(a) Residence. No. 708 Everett St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan 29-1856
7. AGE Years 74 Months 2 Days 2 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER James A. Patton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Helen Vaughn
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Virginia

14. Informant (Address) Ethel A. Ward 808 Everett Caldwell Ida
15. Filed 3-31- 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 31 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1930 to Mar. 31 1930
that I last saw her alive on Mar. 30 1930
and that death occurred, on the date stated above, at 2:30 m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Nephritis
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. M. Riley, M. D.
Mar. 29- 1930 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal: Gooding Ida. Date of Burial 19
20. Undertaker: C. V. Peckham Address Caldwell-Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69844

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 36
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Frank Wade Stivers
(a) Residence. No. Wilder. Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word.): widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 18-1860

7. AGE Years: 70 Months: 2 Days: 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Olin Iowa.

PARENTS

10. NAME OF FATHER Timothy Stivers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Baugh.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Frank Stivers Wilder Idaho.

15. Filed H-4-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 29, 1929, to Mar 29, 1930
that I last saw him alive on Mar 29, 1930
and that death occurred, on the date stated above, at 9:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Robert E Talbot, M. D.
Mar 31, 1930 (Address) Robert E Talbot
MEC 3:30

19. Place of Burial, Cremation, or Removal: Wilder
Date of Burial: April 1- 1930

20. Undertaker: C. V Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69845

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2004
Local Registrar's No. 37
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jane Zaver
(a) Residence. No. Wilder Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 6th 1857

7. AGE Years 72 Months 3 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Franklin Illinois

PARENTS
10. NAME OF FATHER Benner
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Jane Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Mrs L. E. Hahn, Caldwell Ida

15. Filed 3-29, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to March ~~19~~ 27, 1930
that I last saw her alive on March 27, 19..
and that death occurred, on the date stated above, at 11-20 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 1+ yrs. mos. ds.
CONTRIBUTORY (Secondary) Ayr & Interstitial Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) S B Dudley, M. D.
3/27, 1930 (Address) Caldwell, Ida

19. Place of Burial, Cremation, or Removal Roswell
Date of Burial 3/30 1930

20. Undertaker C. V. Peckham
Address Caldwell Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED APR 11 1930

DO NOT WRITE IN THIS SPACE

State File No. 69846

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon

City of Notus

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 28

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Louisia Parish

(a) Residence. No. Notus Idaho St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Aug 28-1860

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	6	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hall county. Missouri

PARENTS

10. NAME OF FATHER John Meyers

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Walter Parish Notus, Idaho.

15. Filed 3-29-, 1930- John L. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 24 1930, to Mar 25, 1930 that I last saw her alive on Mar 25, 1930 and that death occurred, on the date stated above, at 7:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Caused

(Signed) C. D. Frazier M. D.

3/27, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Tucker Cem — Date of Burial: 3-29 1930

20. Undertaker: C. V. Peckham — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69847

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 39
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh Brett
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

16th

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 27 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	5	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Ralph Brett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Langford
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) R D Brett 806 Tellman Caldwell Idaho

15. Filed 3-26-1930 John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Angio 1929 to Mar 23 1930
that I last saw him alive on Mar 23 1930
and that death occurred, on the date stated above, at 9:50 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senile Paresis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R D Brett, M. D.
Mar 25 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt Canyon Hill	Mch 25 1930
20. Undertaker C. H. Peckham	Address Caldwell Ida

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69848

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

71 B0

2. FULL NAME Ray Delbert Ford

(a) Residence. No. Parma Ida R#3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 31- 1921

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
8	11	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho.

PARENTS

10. NAME OF FATHER W. R Ford.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Sarah Seber
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant See Ford
(Address) Parma R#3

15. Filed 3-21-, 1930 John S. Meyer- Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/5, 1930, to 3/19, 1930, that I last saw h[illegible] alive on 3/19, 1930, and that death occurred, on the date stated above, at 5:35 a m.

The CAUSE OF DEATH* was as follows: Complications following Cerebro Spinal Meningitis
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumo (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Questionable
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood Test
(Signed) Dr. H. D. Broadhurst M.D.
3/21, 1930 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. 2:30 P.M.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell	3-21 1930

20. Undertaker	Address
C. V. Peckham	Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69849

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 41

114B

2. FULL NAME Phillip E. Smith

(a) Residence. No. 310 Cleve St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 18 - 1866

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	0	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Real Estate Agt.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Coles Co. Ill.

PARENTS

10. NAME OF FATHER: Thomas W. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Sarah Josephine Roberts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind

14. Informant: C H Hanson
(Address) Cor 9th & Main

15. Filed 3-19-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1927, to March 15, 1930
that I last saw him alive on March 15, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Obstruction of bowels - adhesions and stasis from fracture of spine & injury of cord many years ago.
(duration) several yrs. mos. ds.
CONTRIBUTORY (Secondary) Cystitis, Retention of urine. Result of spinal injury
(duration) many yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of June 26, 1928
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J W Cox, M.D.
3/17, 1930 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 3-18 1930

20. Undertaker: C. H. Peckham
Address: Caldwell Ida

RECEIVED APR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69851

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 2
Primary Registration District No. 2007
(No.)
Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead of street and number.)

1183

2. FULL NAME Martha Stella Moore

(a) Residence. No. Parma Idaho R 3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE — Years | Months: 4 | Days: 9 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Parma PRE

PARENTS
10. NAME OF FATHER: Willard Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Blythedale Mo.
12. MAIDEN NAME OF MOTHER: Ora D Breshears
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Eagle Idaho

14. Informant: Willard Moore
(Address) Parma Idaho R 3

15. Filed Apr 1, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 9 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 A M m.

The CAUSE OF DEATH* was as follows:
Influenza
(This as per advice from County Physician)
(duration) About 3 days yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas L. Bare, M. D.
Mch 10-30 19 (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell Cemetery	Mch 10 -30
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69852

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No 39
(No. 923 - 6th St. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME John Stevens
(a) Residence. No. 923 - 6th St. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wh	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Lillian Stevens

6. DATE OF BIRTH (month, day and year) Sept. 19-1846

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Roswell Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Mirah Beals
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Lillian Stevens
(Address)

15. Filed 3/31, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mar 27, 1930
that I last saw him alive on Mar 26, 1930
and that death occurred, on the date stated above, at 2 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage brain (2nd Stroke)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hemorrhage brain about
Jan 10/30 (duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? Nampa.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Suspected

(Signed) Horace Beltman M. D.
3/27, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal
I.O.O.F. Cem-Nampa.
Date of Burial 3-30 1930

20. Undertaker Wm D. Talley
Address Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 69853

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006 Local Registrar's No. 38
(No. 123-15th ave. no)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Baby Parsons
(a) Residence. No. 123-15th ave. no St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) [illegible]

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 26th 1930

7. AGE Years | Months | Days | If LESS than 1 day, 4 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Pete Parson
11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
12. MAIDEN NAME OF MOTHER Helma D. Potter
13. BIRTHPLACE OF MOTHER (city or town) Blackfoot Idaho
(State or County)

14. Informant (Address) J. R. Potter Nampa Idaho

15. Filed 3/27, 1930 Beth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1930, to Mar 26, 1930
that I last saw her alive on Mar 26, 1930
and that death occurred, on the date stated above, at 2 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uraemic poisoning

2 hrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mother had Puerperal
Uraemia (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V. C. Bellman, M. D.
3/27, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal Lohterlawn - Nampa. Date of Burial 3-27th 1930

20. Undertaker Mrs. Nina M. Tallee Address Nampa, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69856

Local Registrar's No. 34

10

2. FULL NAME John Lewellyn Tidwell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 10 1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	1	12	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Homedale Ida

PARENTS

10. NAME OF FATHER John Leslie Tidwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sunny S ide Utah

12. MAIDEN NAME OF MOTHER Ida Geraldine Carson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oakley Ida

14. Informant Mrs J L Tidwell

(Address) Homedale Ida

15. Filed 3-23, 1930 De Tha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 22-30 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-20-, 1930, to 3-22, 1930
that I last saw him alive on 3-21 1930
and that death occurred, on the date stated above, at 1.35 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis following Diphtheria.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Homedale Ida.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

3-22, 1930 (Signed) L Horton M. D.
(Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cemetery	3-23-30 19
20. Undertaker	**Address**
Paul L. Case	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69857

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 811 - 13th Ave. So)
Local Registrar's No. 33

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phila A. Vaughan 46

(a) Residence. No. 811 - 13th Ave So St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 15th 1863

7. AGE Years 66 Months 8 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico City, New York

PARENTS

10. NAME OF FATHER Isaac N. Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Amanda Whitney
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York

14. Informant (Address) Mrs. Frank Dix Nampa, Idaho

15. Filed 3-20, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1930, to Mar 19, 1930
that I last saw her alive on Mar 17, 1930
and that death occurred, on the date stated above, at 4:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of uterus

(duration) 2 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia in January 1930 (duration) ..... yrs. ..... mos. 18 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
3-7, 1930 (Address) [illegible]

19. Place of Burial, Cremation, or Removal Kohlerlawn - Nampa
Date of Burial 3-20 1930

20. Undertaker Mrs. Nina M. Talley
Address Nampa, Id

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69858

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 32

101 a

PLACE OF DEATH

County of Canyon
City of Rural

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia A Silvers

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of /

6. DATE OF BIRTH (month, day and year) Nov-12-1840

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cincinnati Ohio

PARENTS

10. NAME OF FATHER John B. Weythman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Francis E. Wetter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs A. B. Bruerein
(Address) Nampa Ida R 7 D.

15. Filed 3-21, 1930 Seth Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-16-30, 19, to 3-18, 1930
that I last saw her alive on 3-18, 1930
and that death occurred, on the date stated above, at 4-45 a m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Physical Symptoms
(Signed) A. C. Robinson, M. D.
3-27, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	3-22 1930
20. Undertaker	Address
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 6985.0

Local Registrar's No. 31

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 11 th Ave North)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald E Carter

(a) Residence. No. 11 th Ave North St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30-29

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Ida

PARENTS

10. NAME OF FATHER A E Carter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Provo Utah

12. MAIDEN NAME OF MOTHER Stella Walton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Schofield Utah

14. Informant Mrs A E Carter

(Address) 11 Ave No. Nampa Ida

15. Filed 3—19—1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 16-30 19

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from

, 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Brain infection from mastoid.

(Advice of County Physician)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Carl L. Carver M. D.

3-17-30, 19 (Address) Coroner Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn cemetery	3-18-30 19

20. Undertaker W. E. Tallis Address Nampa Ida

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69866

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1406
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

1080

2. FULL NAME Harriett Hutsell

(a) Residence. No. Davis ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 8-1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10. NAME OF FATHER H. Purce
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Dotson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Fred A. Hutsell
(Address) Nampa Ida.

15. Filed 3-18-1930 Bertha Conner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-13, 1930, to 3-14, 1930
that I last saw her alive on 3-13, 1930
and that death occurred, on the date stated above, at 4 p m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Symptoms
(Signed) A. C. Reisinger, M. D.
3-27, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hohlelawn Cem	3-18 1930
20. Undertaker	Address
Fred K. Robuck	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED APR 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

File No. 69861

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Howard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1905 (Year)

7. AGE: 25 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B J Howard

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Kate Foltz

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D O McPoyntes

(Address) Nampa Idaho

15. Filed 3-9 1930 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1-1930, to 3-9-1930, that I last saw her alive on 3-9-1930 and that death occurred on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary): Influenza

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) D O McPoyntes M. D.

3-9-1930 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 8 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: F. R. Robinson | ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69862

PLACE OF DEATH
County of Canyon
City of

Registration District No. 7
Primary Registration District No. 2006
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

2. FULL NAME Philene P. Duncan
(a) Residence. No. 2 miles west of Nampa St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. D. Duncan

6. DATE OF BIRTH (month, day and year) Aug 24 1841

7. AGE Years 88 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER Moodie Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant L. R. Duncan
(Address) Nampa Idaho R#R#1 + 90x75

15. Filed 3-7, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1929, to Mar., 5th, 1930
that I last saw her alive on Mar., 5th, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Uraemia.
(duration) 0 yrs. 0 mos. 10 ds.
CONTRIBUTORY (Secondary) Chronic Cholecystitis + Nephritis (duration) 4 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Urinary tests + oedema.
(Signed) Geo. O. A. Kluge, M. D.
3-7-, 1930 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ft Ohlerlown Cem Date of Burial Mar 7 1930

20. Undertaker Fred K. Robinson Address Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69863

Local Registrar's No. 27

101 B

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 623 - 14 ave S)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Edward Shehee

(a) Residence. No. 623 - 14 ave S St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER P J Shehee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Dora Childs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant P. J. Shehee

(Address) Nampa Ida

15. Filed 3-6, 1930. Seth A Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to Mar 3, 1930

that I last saw her alive on Mar 3, 1930

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J T Murray, M. D.

Mar 4, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	3-6 1930
20. Undertaker	Address
H T Robinson	Nampa Ida

FORM V. S. N. RECEIVED APR 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. State School St.)

File No. 69864

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert J Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jany (Month) 7 (Day) 1865 (Year)

7. AGE: 62 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): ~~Pa~~ Paris Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susan Simmons

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D F Coyner

(Address) Nampa Idaho

15. Filed 3/23 1930 Lutha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1921, to Mch 22 1930, that I last saw him alive on Mch 22 1930 and that death occurred on the date stated above, at 9.25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D F Coyner M. D.

19..... (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Paris Idaho

19. PLACE OF BURIAL OR REMOVAL: Paris, Idaho

DATE OF BURIAL: 3/24 1930

20. UNDERTAKER: Wm D. Talley

ADDRESS: Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69865

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

126

2. FULL NAME Civian Anna Warren
(a) Residence. No. Kemmerer Wyo St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Otto C Warren

6. DATE OF BIRTH (month, day and year) July 30-1901

7. AGE Years 28 Months 7 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Havre Mont.

PARENTS
10. NAME OF FATHER Edwin E Morcoe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Medford Wis.
12. MAIDEN NAME OF MOTHER Eleanor Terch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Appleton Wis.

14. Informant O. E. Morcoe
(Address) Soda Springs Ida

15. Filed 3-6-1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2/30, 19..., to 3/5/30, 19...
that I last saw he alive on 3/5/30, 19...
and that death occurred, on the date stated above, at 3P m.
The CAUSE OF DEATH* was as follows:
Pertinents
(duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Pus Pinke
(duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? Kemmerer, Wyo
Did an operation precede death? yes Date of 3/2/30
Was there an autopsy? 0
What test confirmed diagnosis? Xamine
(Signed) Elis Kaunley, M. D.
3/5, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Soda Springs Ida — Date of Burial 3-7-1930

20. Undertaker E. S. Whitman — Address Soda Springs Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69866

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 87
Primary Registration District No. 7159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

7180

2. FULL NAME Dale Bee

(a) Residence. No. ..... St. Georgetown, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Feb. 4, 1923

7. AGE Years	Months	Days	If LESS than 1 day,
7	1	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Georgetown Idaho

PARENTS

10. NAME OF FATHER Sharn P. Bee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington Idaho
12. MAIDEN NAME OF MOTHER Helena Flamm
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rexburg Idaho

14. Informant Roy Hoff
(Address) Georgetown, Idaho

15. Filed 3/11, 1930 Dr Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 10, 1930
that I last saw h~~im~~ alive on March 10, 1930
and that death occurred, on the date stated above, at 2:15 a. m.
The CAUSE OF DEATH* was as follows:
Acute meningitis
(duration) ..... yrs. ..... mos 2½ ds.
CONTRIBUTORY (Secondary) Measles
(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? Georgetown, Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Tests
(Signed) Russell Tigert, M. D.
3/11, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Georgetown, Idaho	March 11 1930
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70844

PLACE OF DEATH
County of ~~Bear~~ Carbon
City of Soda Springs

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

71 B

2. FULL NAME Dale F. Bee
(a) Residence. No. Georgetown Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4 - 1923.

7. AGE Years 7 Months 1 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown Idaho

PARENTS

10. NAME OF FATHER Sterns P Bee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington Idaho
12. MAIDEN NAME OF MOTHER Helene Flamm
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rexburg Idaho

14. Informant Sterns P Bee
(Address) Georgetown Idaho

15. Filed 8/30/30 N. Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to Feb 4, 1930
that I last saw him alive on Feb 4, 1930
and that death occurred, on the date stated above, at 4 A.m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Russell Tryert, M. D.
Mar 12, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Idaho
Date of Burial Mar. 12 - 1930

20. Undertaker J. M. William
Address Montpelier Idaho

Duplicate of 1930-69866 VOIDED 9.25.13

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69867

PLACE OF DEATH

County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

122

2. FULL NAME William Winschell
(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Winschell

6. DATE OF BIRTH (month, day and year) Feby 4 - 1860

7. AGE Years 70 Months 1 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Terrahaute Ind

PARENTS
10. NAME OF FATHER Frank Winschell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Longsett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Bert Winschell
(Address) Soda Springs Idaho

15. Filed 3-26, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1929, to March 25, 1930
that I last saw him alive on March 25, 1930
and that death occurred, on the date stated above, at 11 9 m.
The CAUSE OF DEATH* was as follows: Cirrhosis of Liver
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) None
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination
(Signed) Alis Kack Ly M. D.
3-26-1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Soda Springs Ida
Date of Burial 3-28 1930

20. Undertaker E. D. Whitman
Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69868

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

133

2. FULL NAME Annettie Sophia Norstrom
(a) Residence. No. Soda Springs Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Larsen Norstrom

6. DATE OF BIRTH (month, day and year) May 18-1874

7. AGE Years 55 Months 9 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairview Utah

PARENTS
10. NAME OF FATHER Amasa Tucker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Woodstock Conn.
12. MAIDEN NAME OF MOTHER Annettie Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Sophie Stewart
(Address) Soda Springs Ida

15. Filed 3-12, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1924, to March 10, 1930
that I last saw her alive on March 10, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Gallstones

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Mch. 7 1930
Was there an autopsy? no
What test confirmed diagnosis? Phys. Ex. & oper.
(Signed) Russell Tigert, M. D.
3-12-1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 3-13-1930

20. Undertaker D. J. Nichman — Address Soda Springs Ida

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69869

PLACE OF DEATH

County of Caribou
City of Soda Springs
Registration District No. 9 2
Primary Registration District No. 2159
Local Registrar's No. 8

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonard Clarence Childs

(a) Residence. No. Soda Springs Idaho (Usual place of abode) Grace, Idaho (If nonresident give city of town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: Martha Childs

6. DATE OF BIRTH (month, day and year): Jany 16 - 1885

7. AGE: Years 44 | Months 11 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer & Stockraising
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chester Utah

PARENTS

10. NAME OF FATHER: Joel H. Childs
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Athens O Ohio
12. MAIDEN NAME OF MOTHER: Cherste Olsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Martha E Childs
(Address) Soda Springs Idaho

15. Filed 1 - 8 -, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany 5 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1930, to Jany 5, 1930
that I last saw h[illegible] alive on July 5th, 1930
and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Gastric ulcer

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Grace, Ida
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical

(Signed) Russell Jones, M. D.
1 - 8 -, 1930 (Address) Soda Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Soda Springs Idaho	Jany 8 - 1930
20. Undertaker	Address
C L Whiteman	Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69870

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W Wilson 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	W

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Caroline Wilson

6. DATE OF BIRTH (month, day and year) April 4 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Hugh M Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Beatrice Bracy
(Address) Burley Idaho

15. Filed Mar 31, 1930 F. A. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930, to Mar. 20, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Acute Dilation of Heart.

(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. E. Johnson Coroner M.D.
Mar. 20, 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Calif	Mar. 23 1930
20. Undertaker	Address
D. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69871

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

41

2. FULL NAME Maggie Booth

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of H. R. Booth

6. DATE OF BIRTH (month, day and year) Mar. 12 1886

7. AGE Years 44 Months Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER James Henderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Eliza Simpson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant H. R. Booth
(Address) Burley Idaho

15. Filed Mar 23rd, 1930 F. Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1930, to Mar 22, 1930
that I last saw her alive on Mar 22, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Septicemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinic
(Signed) Hugh E. Dean, M. D.
Mar 23, 1930 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wellsville Ut — Date of Burial Mar 25 1930

20. Undertaker D. C. Johnson — Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69872

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH

County of Cassia
City of Burley
RFD 3.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Donald Edgar Anderson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 15, 1930

7. AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida.

PARENTS

10. NAME OF FATHER Christian E Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Ida R Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant C E Anderson
(Address) Burley Ida.

15. Filed 4-10-, 1930 F. H. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15, 1930, to Mar 16, 1930
that I last saw him alive on Mar 16, 1930
and that death occurred, on the date stated above, at 11:50 A m.
The CAUSE OF DEATH* was as follows:
Intra-Uterine Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Hugh E Dean, M. D.
Mar. 30, 1930 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	Mar 19 1930
20. Undertaker	Address
P. O. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 14 1930

PLACE OF DEATH

County of Cassia

City of Burley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.....

Primary Registration District No.....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69873

Local Registrar's No.....

90

2. FULL NAME George Cater

(a) Residence. No..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 75				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Not Not Known

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant D E Johnson

(Address) Burley

15. Filed 4-10-1930 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18, 1930, to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) D E Johnson Coroner M. D.

Mar. 19, 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Mar. 19 1930

20. Undertaker	Address
D E Johnson	Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69874

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

10103

2. FULL NAME Thomas Farrell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 8 1845

7. AGE Years 86 Months Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant James T. Fay
(Address) Burley Ida

15. Filed 2-15-, 1930 F. H. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1930 to Feb. 3, 1930
that I last saw him alive on Feb. 3 1930
and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) Joseph Kemstad M. D.
Feb 11 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial Feb. 6 1930

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

MAR 22 1930

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69875

Local Registrar's No.

162

2. FULL NAME Edna Pearl Gibson

(a) Residence. No. 1111 No Overland St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 22nd 1930.

7. AGE Years Months Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley. Idaho.

PARENTS

10. NAME OF FATHER William H. Gibson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden. Utah

12. MAIDEN NAME OF MOTHER Mary Elmina Meacham.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Henryville Utah.

14. Informant W. H. Gibson
(Address) Burley Ida

15. Filed 3-30, 1930 F H Carter Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1930, to Feb 16, 1930

that I last saw her alive on Feb 16, 1930

and that death occurred, on the date stated above, at 8:00 m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Cord

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Jaundice of new born

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugh E Dean, M. D.

Feb. 25, 1930 (Address) Burley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pella Ida

Date of Burial: Feb 18 1930

20. Undertaker

Address

RECEIVED MAR 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69876

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adrianna McBride Wayley.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Heber C Wayley

6. DATE OF BIRTH (month, day and year) Oct. 10, 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73	4	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Thomas McBride
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ken.
12. MAIDEN NAME OF MOTHER Susan Sampson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ken

14. Informant Howard Allen
(Address) Burley Ida R F D #4

15. Filed 3-15-, 1930 F. H. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 22, 1930
that I last saw her alive on Feb 22, 1930
and that death occurred, on the date stated above, at 11:00 m.
The CAUSE OF DEATH* was as follows:
Cancer of Face

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Dean, M. D.
Feb 24, 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Basin Ida.	Feb 26 1930
20. Undertaker D. E. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69877

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Catherine G Burgess
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C Burgess
6. DATE OF BIRTH (month, day and year) Nov. 29, 1854
7. AGE Years 75 Months 2 Days 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER Robert Cunningham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Ann Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant J. C. Burgess
(Address) Burley Ida
15. Filed 3-1-, 1930 F H Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 28 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to 2-28, 1930
that I last saw her alive on Feby 28, 1930
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:
Mitral Incompetency
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cholecystitis
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clin
(Signed) F H Cutler, M. D.
Mar 1, 1930 (Address) Burley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal American Fork Ct. Date of Burial Mar. 4 1930
20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69878

PLACE OF DEATH
County of Clearwater
City of Elk River

Registration District No. 91
Primary Registration District No. 2168
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Richard Paul Schermerhorn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 11, 1926

7. AGE Years 4 Months Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Elk River, Idaho

PARENTS

10. NAME OF FATHER Paul R. Schermerhorn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nottawa Michigan
12. MAIDEN NAME OF MOTHER Ruth L. McGowan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nottawa Michigan

14. Informant Paul R. Schermerhorn
(Address) Elk River, Idaho

15. Filed April 1, 1930 Mildred Hambly Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 25, 1930
that I last saw him alive on March 25, 1930
and that death occurred, on the date stated above, at 6 45 8 m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) O M Husted M. D.
3/26, 1930 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rockford Washington
Date of Burial: March 28 1930

20. Undertaker: O S Meraga
Address: Spokane
Lunds 169 Idaho

FORM V. S. No. 5-25 M. 1-19. RECEIVED APR 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ....., ... St.)

File No. 69879

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Mae Charllott McKenzie LaVoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: Feb (Month) 15 (Day) 1885 (Year)

7. AGE: 45 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer): None lately

9. BIRTHPLACE (State or Country): Harvard Nebraska

10. NAME OF FATHER: W L McKenzie

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R H Morris

(Address) Elk River Ida

15. Filed April 1 1930 Mildred Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1930 (Year) 46

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1930, to March 18 1930, that I last saw her alive on March 16 1930, and that death occurred on the date stated above, at 6 00 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right Ovary.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O M Husted M. D.

3/18 1930 (Address) Elk River, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Ida

DATE OF BURIAL: March 19 1930

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM No. 5-25 M.D. 19 RECEIVED APR 4 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Elk River Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. Elk River Hospital St.)

File No. 4 69880

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeremiah Paul Shea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word.)

6. DATE OF BIRTH Jan (Month) 9 (Day) 1875 (Year)

7. AGE 55 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business or establishment in which employed (or employer) Self

9. BIRTHPLACE (State or Country) Luzern Iowa

10. NAME OF FATHER B. Shea

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mildred Shea

(Address) Elk River Ida

15. Filed April 1 1930 Mildred Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

101a

16. DATE OF DEATH March (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1930, to March 3 1930 that I last saw him alive on March 2 1930, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 30 ds.

Contributory (Secondary) Emphysema

(Duration) yrs. mos. 20 ds.

(Signed) O M Husted M. D.

3/3 1930 (Address) Elk River, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 2 yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Everett Wash

DATE OF BURIAL March 6 1930

20. UNDERTAKER H E Hunt

ADDRESS St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69881

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 37

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48

PLACE OF DEATH

County of Clearwater
City of Orofino

2. FULL NAME George Smittle

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 30 - 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ?

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W.A. Shaw Coroner
(Address) Orofino

15. Filed 9/30, 19. W.A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3.P m.

The CAUSE OF DEATH* was as follows:
Fund in the river had been there six or eight weeks from the cnndi shion of body

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W.A. Shaw Coroner, ~~M. D.~~
3/29, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	March 30 19
20. Undertaker W.A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69882

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 27

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Joseph Albert Bryant

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 25 1914

7. AGE Years 16 Months 1 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tekean Ida

PARENTS

10. NAME OF FATHER Singleton J. Bryant

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Harrison Arkansas

12. MAIDEN NAME OF MOTHER Elizabeth Patty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) LeGrove Ind

14. Informant S. J. Bryant
(Address) Ahsahka Ida

15. Filed 3/25, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 24, 1930

that I last saw him alive on March 24, 1930

and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) A B Pappenhagen, M. D.

March 25, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cavendish

Date of Burial: March 24 1930

20. Undertaker: W. D. Pinson

Address: Orofino

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69883

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

44

2. FULL NAME Gipson Dorothy

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Dorothy

6. DATE OF BIRTH (month, day and year) Jan 11 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Chas Dorothy
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER [illegible] M Way
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Arthur Dorothy
(Address) Orofino Ida

15. Filed 3/19, 1930. W.A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 18 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to March 18, 1930
that I last saw h[illegible] alive on March 18, 1930
and that death occurred, on the date stated above, at 10.55 p m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Starvation
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1-27-30
Was there an autopsy? no
What test confirmed diagnosis? operation
(Signed) A.B. Pappenhagen M. D.
1-20, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	March 21 19
20. Undertaker W.A. Shaw	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69884

Local Registrar's No. 25

10 A

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ina Kinnes

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Feminine	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bedford James Kinnes

6. DATE OF BIRTH (month, day and year) JAN 1- 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Fort Atkinson Wisc

PARENTS

10. NAME OF FATHER Charles Eustis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Maria

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant B J Kinnes
(Address) Orofino

15. Filed 3/17, 19.... H A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1930, to March 15, 1930
that I last saw her alive on March 15, 1930
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis several

(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) B. J. Hopkins M. D.
3/17/30, 19.... (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Ida	
20. Undertaker H. A. Shaw	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69885

PLACE OF DEATH
County of Shoshone
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

46

2. FULL NAME Ella Moore

(a) Residence. No. ..... St. Warren, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) July 14 - ?

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 60-65	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10. NAME OF FATHER Carl Callan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 4/13, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 7, 1929, to March 6, 1930
that I last saw her alive on March 6 1930
and that death occurred, on the date stated above, at 7.45 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the Uterus

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Psychosis with other somatic diseases (Carcinoma) (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Prior to admission.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John J. McCaffrey, M. D.
March 6, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Northern Idaho Sanitarium Cemetery	March 8 1930
20. Undertaker	Address
F. A. Billberg, Hosp. Mtdt.	Orofino - Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69886

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

122

2. FULL NAME Axel Sundin (Axel F. Sundine)

(a) Residence. No. ..... St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of X
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertai ned

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work "Railroading"
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sweden
(State or country)

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) Unascertained
(State or Country)
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) Unascertained
(State or Country)

14. Informant Records, acds, Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15. Filed 3/13, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to March 1, 1930
that I last saw him alive on February 28, 1930
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:
Cirrhosis of the liver (alcoholic
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) alcoholic psychosis, chronic
paranoid type (duration) 17 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs.
(Signed) John Irvine McKelway, M. D.
March 1, 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Northern Idaho Sanitarium Cemetery
Date of Burial: March 3 1930

20. Undertaker: F. A. Billberg, Hosp. Attdt.
Address: Orofino - Idaho -

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69887

Registration District No. 90 2187
Primary Registration District No.
Local Registrar's No. 22

(No. 74A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Clearwater
City of Orofino

2. FULL NAME Peter Cordell

(a) Residence. No. St. Nelson Hospital
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	?

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 83			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER Cordell ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant Probate Court
(Address) Orofino Idaho

15. Filed 3/13, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 12
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1930, to Mar. 12, 1930
that I last saw him alive on Mar. 11, 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) P. J. Hopkins, M. D.
3/12, 1930 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Idaho	Mar 14 19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69888

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 21

PLACE OF DEATH
County of Clearwater
City of Orofino
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

21

2. FULL NAME Dorithy Ericksons

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25 1908

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Ed Ericksons
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Jennie Kern
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missiouri

14. Informant Ed Ericksons
(Address) Orofino

15. Filed 9 4, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 19 28, to March 6, 19 30
that last saw her alive on March 6, 19 30
and that death occurred, on the date stated above, at 11:00 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) 1 yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical + laboratory
(Signed) H. J. Hopkins, M. D.
3/7/30, 19.... (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Mar 10 19
20. Undertaker W.A. Shaw	Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69889

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 20

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1930

2. FULL NAME James Krumeick

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 29 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	46			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Newyork

PARENTS

10. NAME OF FATHER: Chas Krumeich

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant Granz Krumeick
(Address) Orofino Ida

15. Filed 3/6, 1930. W.A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to March 4, 1930, that I last saw him alive on March 4, 1930, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:
Paralytic Ileus - following ruptured gall bladder
(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic gall bladder disease (duration) — yrs. 6 mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Feb. 22-1930
Was there an autopsy? yes
What test confirmed diagnosis? no

(Signed) A.B. Pappenhagen, M. D.
March 5, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Romulus Ny	19

20. Undertaker	Address
W.A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69890

PLACE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 19
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

76

2. FULL NAME Charles Smathers

(a) Residence. No. ..... St. Lenore, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Belle Smathers

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Henry Smathers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Nancy ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Mar 2, 1930 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1929, to March 1, 1930
that I last saw him alive on March 1, 1930
and that death occurred, on the date stated above, at 8.30 A. m.
The CAUSE OF DEATH* was as follows:
General paralysis of the insane

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Before admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelvey M. D.
March 1, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lenore Ida — Date of Burial: 3/3 19

20. Undertaker: H. A. Shaw — Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69891

PLACE OF DEATH
County of Custer
City of Mackay
Leslie

Registration District No. 16
Primary Registration District No. 2153
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 128

48 30

2. FULL NAME Mrs. Rosetta Perthina Miles

(a) Residence. No. Leslie (Usual place of abode) Idaho St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	wht	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. F. Miles

6. DATE OF BIRTH (month, day and year) June 3 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	3	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Rastus Curtis
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER May Barton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant X Wm F Miles
(Address)

15. Filed 3/27, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-3, 1930, to 3-4, 1930
that I last saw her alive on 3-4, 1930
and that death occurred, on the date stated above, at 12-30 P m.
The CAUSE OF DEATH* was as follows:

acute myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad A Jensen, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Leslie, Idaho	March 7 1930
20. Undertaker	Address
Theo. R. Garnier	Mackay, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 31 1930

PLACE OF DEATH

County of Custer

City of Mackay

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 76

Primary Registration District No. 2153

DO NOT WRITE IN THIS SPACE

State File No. 69892

Local Registrar's No. 127

(No. 940)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Washington Mc Lerran

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	wt	Marrid

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Beatrice Mc Lerran

6. DATE OF BIRTH (month, day and year) June 7- 1880

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER James McLerran

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Sara Clifton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Beatrice Mc Lerran

(Address)

15. Filed Mar. 27, 1930 Rose Nowacki Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 12 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1/29, 19 to 2/12/30, 19 that I last saw him alive on 2/11/30, 19 and that death occurred, on the date stated above, at 5 PM m.

The CAUSE OF DEATH* was as follows:

CHRONIC ENDOCARDITIS

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) NEPHRITIS, CHRONIC

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? CLINICAL

(Signed) F. P. Richards, M. D.

2/12/30, 19 (Address) Mackay, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Caleb Mackay	2/14 1930

20. Undertaker Address

Theo R Garmire Mackay

RECEIVED APR 5 1930

~~TRANSPORTATION OF CORPSE~~

(Always write with black ink)

1. PLACE OF DEATH

County of Elmore

City of Mt Home Ida

If death occurs away from usual residence give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

2. FULL NAME Emma Brown

State of Idaho
DEPT. OF PUBLIC WELFARE
Bureau of Vital Statistics

File No. 69893

Register No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate at place of death

PERSONAL AND STATISTICAL PARTICULARS

3. SEX. F

4. COLOR OR RACE. white

5. Single, married, Widowed or Divorced. Widowed (Write the Word.)

6. DATE OF BIRTH. March (Month) 4 (Day), ~~19~~ 1858 (Year)

7. AGE. 72 Yrs. ..... Mos. 15 ds.

IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE. (State or Country.) Wisconsin

10. NAME OF FATHER. George Marsh

11. BIRTHPLACE OF FATHER. (State or Country.) unknown

12. MAIDEN NAME OF MOTHER. not known

13. BIRTHPLACE OF MOTHER. (State or Country.) do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J H Boyle

(Address) Mt Home

15. Filed 3/22, 1930 [signature] Local Registrar.

Place Where Remains Are To Be Sent | Date of Shipment ....., 192...

SHIPPING UNDERTAKER G. S. Zacher

ADDRESS Mt Home Ida Firm Name .....

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH. Mar (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-15-, 1927, to 3-19-, 1930; that I last saw her alive on 3-19-, 1930, and that death occurred on the date stated above, at 7 P.M. The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(Duration) 6 Years ..... mos. ..... ds.

Contributory (Secondary.) .....

(Duration) ..... Years ..... mos. ..... ds.

Signed T. E. Evans, M. D.

3-22-1930 (Address) Mtn. Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (for Hospitals, Institutions, Transient or Recent Residents.)

At place ..... in the .....

of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL. Nampa Ida

Date of Burial. 3/22, 1930

20. UNDERTAKER. G. S. Zacher

Address Mt Home Ida

FORM VI-2 No. 5-25 M. 1-19. RECEIVED MAR 20 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

File No. 69895

Registered No. #4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Hooker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Unknown

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Hand

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. S. Zacher

(Address) Mt. Home Ida

15. Filed Mar 3 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 17 1930, to Feb - 24 1930 that I last saw him alive on Feb - 24 1930, and that death occurred on the date stated above, at 12.35 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral infarct or embolus, left, from senile gangrene all toes right and left

(Duration) 0 Yrs. 0 mos. 7 ds.

Contributory (Secondary) Senile gangrene both feet

(Duration) 2 yrs. — mos. — ds.

(Signed) [signature] M. D.

2-25 1930 (Address) Mountain Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. Home Idaho

DATE OF BURIAL: 2-25 1930

20. UNDERTAKER: G. S. Zacher

ADDRESS: Mt. Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19..

REGISTERED MAR 20 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 69896
Registered No. 3

1. PLACE OF DEATH
County of Elmore
City of Mt. Home
(No. ..... St. .....)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank O. Lennart Lennart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Widowed

6. DATE OF BIRTH Unknown (Month) (Day) 1 (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. S. Zacher
(Address) Mt. Home Ida

15. Filed Mar 3 1930 H. H. Anderson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2- 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-11 1930 to 2-18 1930
that I last saw h.... alive on 2-18 1930
and that death occurred on the date stated above, at 1.50 A.M.
The CAUSE OF DEATH* was as follows:
Hemorrhage left fissure Rolandic - paralyzed left face and right body -
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) This is the third stroke -
(Duration) 10 yrs. — mos. — ds.
(Signed) Dr. C. P. Hamilton M. D.
2-19 1930 (Address) Mountain Home, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt. Home Ida.	2-19 1930

20. UNDERTAKER	ADDRESS
S. S. Zacher	Mt. Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAR 20 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Mt. Home

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 34

Primary Registration District No. 2020

(No. ..... , ... St.)

File No. 69897

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Ernest Knight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: April (Month) 24th (Day) 1908 (Year)

7. AGE: 21 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mechanic

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John Knight

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lydia Grace Rena

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace Knight.

(Address) Mt. Home Ida.

15. Filed Mar 3 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

24

16. DATE OF DEATH: Feb. (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1930, to Feb 4 1930, that I last saw him alive on Feb 4 1930, and that death occurred on the date stated above, at 12.15 P.M.

The CAUSE OF DEATH* was as follows:

Epidemic cerebro-spinal Meningitis.

..... (Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) —

— (Duration) — Yrs. — mos. — ds.

(Signed) Dr. O. P. Hamilton M. D.

2-5 1930 (Address) Mountain Home, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Mt. Home Ida.

DATE OF BURIAL: 2-5 1930

20. UNDERTAKER: G. S. Zacher.

ADDRESS: Mt. Home Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69898

PLACE OF DEATH
County of Oneida Co. Preston Ida Franklin Co.
City of Cedar City
Registration District No. 53
Primary Registration District No.
(No.)
Local Registrar's No. 144
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Henry Davis 90

(a) Residence: No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 4 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Elizabeth Humpheys

6. DATE OF BIRTH (month, day and year): Oct. 30, 1870

7. AGE: Years 59 | Months 4 | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cedar City Iron Co.

PARENTS

10. NAME OF FATHER: James Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): London England
12. MAIDEN NAME OF MOTHER: Mary Elizabeth Dredell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): London England

14. Informant: Mary A. Davis
(Address): Paris, Idaho.

15. Filed March 10, 1930 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1929 to May 30, 1929
that I last saw h alive on Oct. 20 1930
and that death occurred, on the date stated above, at 5:00 P. m.
The CAUSE OF DEATH* was as follows: Heart Desease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY. (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No. What test confirmed diagnosis? Coroners Verdict by Jury Found systolic murmur at apex Heart Disease
(Signed) Clarence H. Bell M. D.
March 7, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: March 11 1930

20. Undertaker: Mr. Hendricks — Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69899

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Johanna C. Andraesen

(a) Residence, No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Knud Andraesen

6. DATE OF BIRTH (month, day and year) Aug I6 I845

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	7	I3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Christeffer Christofferse n

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Christena Christensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant A. B. C. Jensrn
(Address) Preston

15. Filed Mar 21, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] Barney, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grace Idaho Mpr — Date of Burial I 1930

20. Undertaker M. W. Hendricks — Address Preston

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69906

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lester Eric Christensen

9

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 24 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work BABY
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER James A. Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mt. Plesant Utah
12. MAIDEN NAME OF MOTHER Naomi Nelsen
13. BIRTHPLACE OF MOTHER (State or Country) Preston Idaho

14. Informant James A. Christensen
(Address) Preston Idaho

15. Filed 3-29, 1930 A. P. Cooley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-13, 1930, to 3-29, 1930
that I last saw him alive on 3-27, 1930
and that death occurred, on the date stated above, at 1 40 a.m.

The CAUSE OF DEATH* was as follows:
Pertussis
(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. S. Mulford M. D.
3-29, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Mar 31 30
20. Undertaker M. W. Hendricks	Address Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69902

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

74a

2. FULL NAME Joseph Barnes

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Rebecca A. Barnes

6. DATE OF BIRTH (month, day and year): Mar 8 1857

7. AGE: Years 73 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: None of late years
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: James Barnes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Ann Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Mrs. Chrissie B. Owens
(Address): Glendale Idaho

15. Filed Mar 11, 1930 — A. P. Cutler, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 6, 1930, to ....., 19....
that I last saw h.. alive on Mar, 1930
and that death occurred, on the date stated above, at 8:30 a m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Diabetis Several years standing -
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.
March, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Mar 12, 1930

20. Undertaker: M. W. Hendricks — Address: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69903

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
(No. ....)
Local Registrar's No. ....

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reed Claud Ransom

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 6 1928

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work BABY
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Paris Idaho

PARENTS

10. NAME OF FATHER Heber J. Ransom

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cleveland Idaho

12. MAIDEN NAME OF MOTHER Velma Prescott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sharon Idaho

14. Informant Heber J. Ransom
(Address) Cleveland Idaho

15. Filed Mar 11, 1930 A. R. Curley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 28, 1930, to Mar 4, 1930
that I last saw him alive on Mar 4, 1930
and that death occurred, on the date stated above, at 7a m.
The CAUSE OF DEATH* was as follows:
Pneumonia and Empyema
(duration) yrs. 1 mos. 14 ds.
CONTRIBUTORY (Secondary) Measles 12 weeks
Pneumonia (duration) yrs. 3 mos. — ds.

18. Where was disease contracted if not at place of death? Idaho Falls Ida
Did an operation precede death? Yes Date of Febr 29 30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. Slater, M. D.
Mar 5, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
~~Cleveland Idaho~~	~~Mar 6 30~~
20. Undertaker M. W. Hendricks	Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69904

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Arvilla Lindsay

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 15 1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	22	2		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ovid Idaho

PARENTS

10. NAME OF FATHER LeRoy Lindsay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Paris Idaho
12. MAIDEN NAME OF MOTHER Josephine Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ovid Idaho

14. Informant LeRoy Lindsay
(Address) Preston Idaho

15. Filed Mar. 18, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to March 15, 1930
that I last saw her alive on March 15, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

George Lefty
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. P. Curtis, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Mar 18 19 30

20. Undertaker M. W. Hendricks Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69905

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

188e

2. FULL NAME William Lewis Harris

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ethel Harris

6. DATE OF BIRTH (month, day and year): Dec I 1877

7. AGE: Years 52 | Months 3 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: FARMER
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Fairview Idahi

PARENTS

10. NAME OF FATHER: Joshua Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country): South Wales
12. MAIDEN NAME OF MOTHER: Ann Whitesids
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kaysville Utah

14. Informant: Ira L. Harris
(Address): Preston Idaho

15. Filed Mar. 27, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to March 23, 1930
that I last saw him alive on March 23, 1930
and that death occurred, on the date stated above, at 8.40 P. m.
The CAUSE OF DEATH* was as follows:
Fracture of Skull
Automobile accident
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): fractured skull
✓ (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? accident
Did an operation precede death? no Date of ✓
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. R. Cutler ~~M. D.~~ Coroner
3/25, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairview Idaho Mar | Date of Burial: 27 30 19

20. Undertaker: M. W. Hendricks Preston | Address

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69907

PLACE OF DEATH

County of Franklin

City of ~~Preston~~ Weston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Loraine Kofoed

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	~~married~~ widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 18 76

7. AGE	Years	Months	Days	If LESS than 1 day,
	54	I	I9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kanab Utah

PARENTS

10. NAME OF FATHER Adam Campbell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Elizabeth Beebe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Edith K. Taylor
(Address) Salt Lake City Utah

15. Filed Mar 11, 1930 A. R. Curtis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-24, 1930, to 3-6, 1930
that I last saw her alive on 3-5, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Pneumonia
ends Carditis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) A. R. Curtis, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston	Mar 10 30

20. Undertaker	Address
M. W. Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69908

PLACE OF DEATH
County of Franklin
City of Weston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10

2. FULL NAME Henry Christen Ehrlick

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace L. Ehrlick

6. DATE OF BIRTH (month, day and year) Jan 30 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8. OCCUPATION OF DECEASED MILLER
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) OHIO (State or country)

PARENTS

10. NAME OF FATHER Ehrlick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Elizabeth Ehrlick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Grace L. Ehrlick
(Address) Weston Idaho

15. Filed Mar 27, 1930 A. P. Wooley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

I never met him nor H Ehrlick in his life But visit him at his home the day of death with my appriment (duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) of cardiac from the history the family gave me (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Thos B Holder M. D.
3/25, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	Mar 26 1930

20. Undertaker W. Hendricks Address Preston

M

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69909

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 101a

2. FULL NAME Willard McKinley Hughes

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22-1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	—	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sawmill worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Charles Hughes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Margaret Sweeney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant C E Newsom
(Address) Emmett Idaho

15. Filed 3/15, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to Mar 14, 1930
that I last saw h~ alive on March 13, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
3/15, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	3/16 1930

20. Undertaker C D Buckmun — Address Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. 1-A-25M. 1-19. RECEIVED APR 7 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69910

Local Registrar's No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 6

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald LaVern Lubcke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word)

6. DATE OF BIRTH: March (Month) 9 (Day) 1930 (Year)

7. AGE: Yrs. Mos. ds. 3

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Emmett Ida

10. NAME OF Father: Martin Carl Lubcke

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Regina Hellen Conrad

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M C Lubcke
(Address) Emmett Ida

15. Filed 3-9- 1930 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH 160

16. DATE OF DEATH: Mar (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1930, to Mar 9 1930, that I last saw him alive on March 8 1930, and that death occurred on the date stated above, at 1-15 A.M.

The CAUSE OF DEATH* was as follows:
Ichthius Neonatorium — possibly some lives condition

(Duration) yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J L Reynolds M. D.

19 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida

DATE OF BURIAL: 3-9 1930

20. UNDERTAKER: M C Lubcke (Father)

ADDRESS: Emmett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6991

PLACE OF DEATH
County of Glen
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 125)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jemima J. Sanders

(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
fem	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 16 - 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Du Page County Illinois

PARENTS

10. NAME OF FATHER John Medland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Sleep
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Roy Sanders
(Address) Emmett Ida

15. Filed 2/28, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 24, 1930
that I last saw h- alive on Feb 24, 1930
and that death occurred, on the date stated above, at 4 50 m.

The CAUSE OF DEATH* was as follows:
Acute pancreitis
this seems to follow
an acute urinary
infection (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. L. Reynolds, M. D.
2/28, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	3/2 1930

20. Undertaker C. A. Buckmann — Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69912

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No. 6
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Della May Sorensen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25-1913

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS
10. NAME OF FATHER: A. Sorensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Etta Beutler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Andrew E Sorensen
(Address)

15. Filed , 19 . J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Mar 10, 1930
that I last saw her alive on March 6, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
General Septicemia Septic Indo-carditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Septic tonsils
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
3-11, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 3/13 1930

20. Undertaker: C D Buckman
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. [illegible] M. 1-19. RECEIVED APR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 69913

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George DeWitte Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 7 (Day) 1914 (Year)

7. AGE: 15 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: attending school

(b) General nature of industry, business or establishment in which employed (or employer): Lived on farm

9. BIRTHPLACE (State or Country): Fairfield Ida

10. NAME OF FATHER: Geo. W. Wells

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Minnie E. Mink

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. W. Wells

(Address) Gooding Ida

15. Filed 3/25 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1930 (Year) 10 A

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1930, to 3-25 1930 that I last saw him alive on 3-25 1930, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.

3/25 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida

DATE OF BURIAL: 3-28 1930

20. UNDERTAKER: H. E. Thompson

ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED APR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 24

County of

Primary Registration District No.

File No. 69914

City of

(No. St.)

Registered No. 125

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William A. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1858 (Year)

7. AGE: 72 Yrs. Mos. 1 ds. 4

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Richard Phillips

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Margarette Lukin Luker

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susie Jean Phillips

(Address) Gooding, Ida.

15. Filed 3/31 1930 J. H. Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 12 (Day) 1930 (Year) 74a

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1930, to March 12 1930 that I last saw him alive on March 12 1930, and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Houston E. Snyder M. D.

3-14 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. [illegible] APR 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Gooding, Idg

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 24

(No. , St.)

File No.

Registered No. 125

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 2 (Month) — 18 (Day) 1858 (Year)

7. AGE: 72 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Richard Phillips

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Margaret Luker

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susy Dean Phillips

(Address) Gooding, Idg

15.

Filed 3/31 1930

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) — 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20 1930, to 3-12 1930 that I last saw him alive on 3-12 1930 and that death occurred on the date stated above, at 3:00 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. 1 ds.

(Signed) Houston E. Snyder M. D.

3/30 1930 (Address) Gooding, Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Idaho

DATE OF BURIAL: 3-15 1930

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding, Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. 5-25 M. 1-19 APR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 6015
Registered No. 124

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred Johanson Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept. (Month) 25th (Day) 1929 (Year)

7. AGE: Yrs. 5 Mos. 21 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Alfred Johanson

11. BIRTHPLACE OF FATHER (State or Country): Hawaiian Islands

12. MAIDEN NAME OF MOTHER: Mary Obanheim

13. BIRTHPLACE OF MOTHER (State or Country): New York City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs A Johanson
(Address): Fairfield Ida

15. Filed 3/31 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-14-'30 19..., to 3-15-30 19..., that I last saw him alive on 3-15-30 19..., and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J H Cromwell M. D.
3/15 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairfield Ida — DATE OF BURIAL: 3/16/1930

20. UNDERTAKER: A.E. Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

REC'D APR 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... , ... St.)

File No. 69916

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Arnzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) ..... (Day) 1922 (Year)

7. AGE: 8 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Green Creek, Idaho.

10. NAME OF FATHER John Arnzen

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Catherine Dasenbrock

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Hupoll

(Address) Green Creek, Ida.

15. Filed Mar. 6 1930 W. F. Orr per I.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

126

16. DATE OF DEATH: March (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 1930, to Mar 5 1930, that I last saw him alive on Mar. 5 1930 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Wesley F. Orr M. D.

Mar 6 1930 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek, Ida.

DATE OF BURIAL: 3/7 1930

20. ~~UNDERTAKER~~ Father Baerlocher, Green Creek, Ida.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED APR 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69917

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 6

PLACE OF DEATH
County of Idaho
City of Grangeville
(No.) 170
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joshua Phillips

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wood Chopper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Tom Neal

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant G. L. Slichter
(Address) Grangeville Idaho

15. Filed 4-1-, 1930 D Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Suicidal Gun Shot —
Mouth
(duration) Sudden yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) G A Hancock Coroner, M. D.
3-31-, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	4-1-1930
20. Undertaker	Address
Hancock Mtg. Co.	Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH 98

County of Jefferson
City of Labelle

Registration District No. 98
Primary Registration District No. 2176
(No.)

DO NOT WRITE IN THIS SPACE
State File No. 69918
Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Jesse Olonzo Fifield.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (~~WIFE of~~) Clara V. Fifield.

6 DATE OF BIRTH (month, day and year) Apr. 4, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10 NAME OF FATHER Mark G. Fifield.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Sallie Ann Ballenger.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Clara Fiefield.
(Address) Labelle, Idaho.

15 Filed MAR 1 1930 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March (Month) 7 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to Mar. 7, 1930, that I last saw h~~i~~m alive on Mar. 6, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate & Atrophy of Ureters (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. R. Hart M. D.
3/11, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Annis, Idaho.	3/10/30

20. Undertaker A. B. Eckersell Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69919

PLACE OF DEATH

County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 2

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Jane C. Kinghorn.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Widowed.

5a. If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Alexander Kinghorn.

6. DATE OF BIRTH (month, day and year) December 15, 1843

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10. NAME OF FATHER David Campbell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Jane Izett.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Jennie Tall.
(Address) Rigby, Idaho.

15. Filed MAR 1 1930, 19.... C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1930, to Feb 26, 1930
that I last saw h~~er~~ alive on Feb 24th, 1930
and that death occurred, on the date stated above, at 1:30 P. m.
The CAUSE OF DEATH* was as follows:
Senility:
to bed to days
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) 86 yrs
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) A. C. Anderson M D, M. D.
Mar 3 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	3/3/30 19

20. Undertaker A. O. Eckersell Address Rigby

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69920

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 4

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Winifred Claire Lockes.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married,

5a. If married, widowed, or divorced
(or) WIFE of Charles Lockes.

6. DATE OF BIRTH (month, day and year) Feb. 23, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	10	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming.

PARENTS

10. NAME OF FATHER Bynom Lane.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia.

12. MAIDEN NAME OF MOTHER Lenora Daniels.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mr. Charles Lock.
(Address) May Idaho.
C. H. GAVIN, M.D.

15. Filed , 19 APR 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1930, to , 19 , that I last saw her alive on Jan 1st, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows: Was dead when I got there Probably myocarditis and Coronary Thrombosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. C. Anderson, M. D.
, 19 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	1/17/30 19

20. Undertaker C. B. Erickson Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69921

PLACE OF DEATH
County of Jefferson
City of St. Anthony Ida.

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 5

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Ann Smithies Beck.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Theodore Beck

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 63 | Months 8 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake Utah

PARENTS

10. NAME OF FATHER: Robert Smithies
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elizabeth Scott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Neb.

14. Informant: Sarah Smithies Rostan
(Address): Lorenzo Ida.

15. Filed MAR 1 1930 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1928, to Feb 2, 1930
that I last saw her alive on Feb 2, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Acute Endocarditis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) C. W. Sutherland, M. D.
2-3, 1930 (Address) Rexburg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cedar Butes	Feb. 5th 1930
20. Undertaker	Address
Wm. J. Keller	Rexburg Ida.

RECEIVED APR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69924

PLACE OF DEATH
County of Twin Falls
City of ~~Twin Falls~~ Eden

Registration District No. 23
Primary Registration District No. 2017
(No.) 179
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Nancy Southwood
(a) Residence. No. St. Dr Clausheck
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 9 / 1842
7. AGE 88 Years Months 9 Days 17 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ind

PARENTS
10. NAME OF FATHER X X
11. BIRTHPLACE OF FATHER (city or town) (State or Country) X X
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X X

14. Informant J M Southwood
(Address) Eden
15. Filed Apr 1, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1930 (Month) (Day) (Year) 6-30
17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1928, to Feb 16, 1928
that I last saw her alive on Feb 16, 1928
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? winning test.
(Signed) H W Clausheck, M. D.
March 26, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls
Date of Burial 19
20. Undertaker E C Drake
Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible] APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69925

PLACE OF DEATH
County of Koolenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

105

2. FULL NAME Frank Lee
(a) Residence. No. 213 - Garden St.
(Usual place of abode) Hayden Lake (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Callie Lee

6. DATE OF BIRTH (month, day and year) 1866 - 11 - 8

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Boat Captain
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Owned own boats

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER — Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs Callie Lee
(Address) Hayden Lake, Ida

15. Filed 3 - 27, 1930. N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 - 24, 1930, to 3 - 4, 1930
that I last saw ~~him~~ alive on 3 - 4 - 1930
and that death occurred, on the date stated above, at 1 15 9 m.
The CAUSE OF DEATH* was as follows:
Cardiac Asthma
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Asthma
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. H. Teed, M. D.
3 - 8 -, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest-Cem. C D Alene — Date of Burial 3 - 9 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6992 6

Registration District No. 20
Primary Registration District No. 1050
Local Registrar's No. 38

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene
(No. Reid Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74 a

2. FULL NAME Willard A Hicks

(a) Residence. No. 802 Second St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1858 — 3 — 4

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	0	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Frank Hicks
(Address) Coeur d Alene Ida

15. Filed 3/27, 1930 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 - 9 -, 1930, to 3 - 11, 1930
that I last saw him alive on 3 - 11 -, 1930
and that death occurred, on the date stated above, at 9 A m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. H. Teed M. D.
3 - 13 -, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	3/13 1930

20. Undertaker: A B Mooney — Address: Coeur d Alene

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69927

Registration District No. ____
Primary Registration District No. ____
Local Registrar's No. 40

(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

2. FULL NAME Elmer Berglund

(a) Residence. No. ____ St. Spirit Lake Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of ____
(or) WIFE of ____

6. DATE OF BIRTH (month, day and year) January 20-1904

7. AGE

Years	Months	Days	If LESS than 1 day,
25	9	14	____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millwrker
(b) General nature of industry, business, or establishment in which employed (or employer) Grading Lumber
(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) Lindevall Sweden

PARENTS

10. NAME OF FATHER Victor Berglund
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lundevall Sweden
12. MAIDEN NAME OF MOTHER Alma Strom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Vrey Berglund
(Address) Spirit Lake Idaho

15. Filed 3/27, 1930 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) - 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-3-, 1930, to 3-6-, 1930
that I last saw ____ alive on 3-6-, 1930
and that death occurred, on the date stated above, at 4 05 P m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Bowels
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Tuberculosis of lungs
(duration) 1 yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Lewiston Ida.
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? ____
(Signed) E. H. Teed, M. D.
3-7-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery, Spirit Lake Ida	3-10 1930
20. Undertaker Cassedy Funeral Home	Address Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No.....

Primary Registration District No.....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69928

Local Registrar's No. 41

47

2. FULL NAME LILLIAN C. SIMONS.

(a) Residence. No. 610 Foster St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 22 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	2	4	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER J. B. Lemley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant Mrs A I Salsbury

(Address) Coeur d Alene Idaho

15. Filed 3/27, 1930 H. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to March, 1930, that I last saw her alive on March 26, 1930, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) K. D. Kahlke M. D.

Mar. 26 1930 (Address) Spokane.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Helena Mont	Mch 29 1930

20. Undertaker	Address
P. J. Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69929

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

483.

2. **FULL NAME** James R. Buchanan

(a) Residence. No. Hayden Lake St.
(Usual place of abode)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1863 - 2 - 19

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant L. J. Klepfner
(Address) Coeur d'Alene, Ida.

15. Filed 3/28, 1930 N. J. Stringer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to March 11, 1930
that I last saw him alive on March 11, 1930
and that death occurred, on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was as follows:
Ch. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Stringer, M. D.
3-13, 1930 (Address) CDA, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	3/14 1930

20. Undertaker C. B. Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69936

Local Registrar's No. 43

PLACE OF DEATH
County of Kootenai
City of Hayden Lake
Registration District No. 3
Primary Registration District No. 1050
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Reed

(a) Residence. No. farm — St. Hayden Lake, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1876 - Oct. 1

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Eldridge Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Susan Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant William A. Reed
(Address)

15. Filed 3/28, 1930 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1928, to March 8, 1930
that I last saw her alive on March 8, 1930
and that death occurred, on the date stated above, at 11:20 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy,
(2nd attack)
one (duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) General Arteriosclerosis
one (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank D. Stern, M. D.
3/10, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C D'Alene	3-11 1930
20. Undertaker Cassedy Funeral Hm	Address C D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69931

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 44
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Theresa Travis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. about 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Albert Travis

6. DATE OF BIRTH (month, day and year) April 25-1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	11	22	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Markton Wisconsin Minnesota

PARENTS

10. NAME OF FATHER — — Londrith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known - Minn?

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Leo Travis
(Address) E825 Mission Spokane

15. Filed 3/27, 1930 H. J. Stinges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 10, 1928, to March 17, 1930
that I last saw h[illegible] alive on March 16, 1930
and that death occurred, on the date stated above, at 9.00 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Arteriosclerosis -

about 2 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Frank Wenz, M. D.
3/18, 1930 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Evergreen Cemetery, Post Falls Ida	3/19 1930
20. Undertaker Cassedy Funeral Home	Address Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

R[illegible] APR 9 1930

PLACE OF DEATH

County of Kootenai

City of Rathdrum

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69029

Local Registrar's No. 45

74C

2. FULL NAME Emanuel L Von Hoeen

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Von Hoeen

6. DATE OF BIRTH (month, day and year): Sept 22/1866

7. AGE — Years: 63 | Months: 5 | Days: 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): New York City / New York State

PARENTS

10. NAME OF FATHER: Augt Von Hoeen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Myra D Childs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. Elizabeth Von Hoeen

(Address): Rathdrum Ida

15. Filed 3/31, 1930 H. J. Sturgeon, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1927, to March 6, 1930

that I last saw h[illegible] alive on March 5, 1930

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) about 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank Wann, M. D.

3/8, 1930 (Address) Rathdrum Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery - Rathdrum — Date of Burial: 3/10 1930

20. Undertaker: Casady Funeral Home — Address: Rathdrum

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69933

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 46

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME John Yana

(a) Residence. No. Bellgrove Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1854 - April 9

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER John Yana
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Agnes Schantauch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant C. W. Yana
(Address) Westport Wash

15. Filed 3/31, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to March 20, 1930
that I last saw him alive on March 20, 1930
and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Exam.
(Signed) Harold J. Sturges, M. D.
3-22, 1930 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. CD Alene
Date of Burial: 3-23 1930

20. Undertaker: Cassedy Funeral Home
Address: CD Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69934

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No.
Primary Registration District No.
Local Registrar's No. 47

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Nelson

(a) Residence. (No. 1717- Sherman St. 207
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Garlwick Nelson

6. DATE OF BIRTH (month, day and year) 1901 - 6 - 12

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	8	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Hans K. Jessing

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Dorothy Mandahl

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs John Nelson
(Address) Coeur d' Alene, Ida.

15. Filed 3/31, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 11, 1930
that I last saw h~~e~~r alive on March 11, 1930
and that death occurred, on the date stated above, at 7 10 P m.
The CAUSE OF DEATH* was as follows:

Sleeping Sickness

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 hours

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold T. Anderson, M. D.
March 11, 1930 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Milwaukee, Wis	3-17 1930
20. Undertaker	Address
Casady Funeral Home	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69935

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1057

Local Registrar's No. 48

(No.) 75
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Jane Stout

(a) Residence. No. Post Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 13, 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	4	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Andrew Calvin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Diana Goode

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Mrs Maggie Matlock
(Address) Post Falls Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to Feb 17, 1930
that I last saw her alive on Feb 17, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

General Paralysis

(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) arterio-Sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Symptoms

(Signed) F. L. McCaulley M. D.
Mar 18, 1930 (Address) Post Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Thornton Rock	3/19 1930

20. Undertaker	Address
J. W. Mahoney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69936

Local Registrar's No. 49

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene Ida.
Registration District No. 30
Primary Registration District No. 1050
(No. Not in hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Thomas Plumb

(a) Residence. No. 810 Montana Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Caroline L Harvey Plumb

6. DATE OF BIRTH (month, day and year) March 11th 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	11	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Log Scaler (retired)
(b) General nature of industry, business, or establishment in which employed (or employer) Woods and Mill work
(c) Name of employer Not Employed

9. BIRTHPLACE (city or town) (State or country) Lake Mills Wisconsin U.S.A.

PARENTS

10. NAME OF FATHER Charles Plumb
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boston Massachusetts
12. MAIDEN NAME OF MOTHER Delia Klem
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known New York

14. Informant Mrs Caroline L Plumb
(Address) 810 Montana Ave, Coeur d'Alene

15. Filed 3/31, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from _____, 19__, to _____, 19__
that I last saw h— alive on _____, 19__
and that death occurred, on the date stated above, at about 11 A m.
The CAUSE OF DEATH* was as follows:
Drowned
Accidental
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No Tests
(Signed) Harold J. Sturges M. D.
3-14, 1930 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD Alene	3-16 1930
20. Undertaker	Address
Cassedy Funeral Dir Inc	CD Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69927

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 50

(No.) 1000 a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Gross.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Don't know exactly

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	Don't know		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't know.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C. McDonald
(Address) Coeur d'Alene Ida.

15. Filed 4/7/, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1930, to Mar. 30, 1930
that I last saw him alive on Mar. 29, 1930
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John Allwood, M. D.
April 1, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Athol - Cem. Idaho	4-2 1930
20. Undertaker	Address
Cassedy Funeral Dir.	C'Dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 69938

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 51

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Margerett Minta Carey

(a) Residence. No. 1323 North 4th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 12, 1854

7. AGE

Years	Months	Days	If LESS than 1 day,
75	3	17	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lexington
(State or country) Ky.

PARENTS

10. NAME OF FATHER Westley Beck

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ind.

12. MAIDEN NAME OF MOTHER Ann McVey

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) U. S.

14. Informant John Carey,
(Address) Spokane, Wn.

15. Filed 4/7/, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Mch 29, 1930

that I last saw her alive on Mch 27, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) J. C. Dwyer M. D.

Mch 29, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: March 31, 1930

20. Undertaker: R B Mooney

Address: Coeur d'Alene

RECEIVED APR 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69929

PLACE OF DEATH
County of Kootenai
City of Coeur A' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 52
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rhoda V. Clark

(a) Residence. No. 317 Military Drive St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug, 2, 1849

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	7	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Solomen Haydenon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Judith Haskell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Mrs. J. C Dwyer
(Address) Coeur D' Alene, Idaho

15. Filed 4/7, 1930 Harold J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August, 1928, to Apr. 2, 1930
that I last saw h[er] alive on Apr. 2, 1930
and that death occurred, on the date stated above, at 920 a. m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis, hypertension
Cerebral hemorrhage (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. G. Dwyer, M. D.
Apr. 2, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Charles, Minn	4/8 1930

20. Undertaker R B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69940

PLACE OF DEATH
County of Koolenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

1889

2. FULL NAME John J Browning
(a) Residence. No. ..... St. Springston Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Amy Wells Browning

6. DATE OF BIRTH (month, day and year) July 22, 1865

7. AGE Years: 64 Months: 7 Days: 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer): Saw Mill
(c) Name of employer: Russell & Pugh

9. BIRTHPLACE (city or town) (State or country): Carthage Ill

PARENTS
10. NAME OF FATHER: George Browning
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Hannah Ramsey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Mrs. Amy Browning
(Address) Springston Idaho

15. Filed March 28, 1930 H.W. Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to March 27, 1930
that I last saw him alive on March 27, 1930
and that death occurred, on the date stated above, at 7:15 A.m.
The CAUSE OF DEATH* was as follows:
Trauma of mesentary of stomach and duodenum & jejunum. Hemorrhagic.
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Accidental crushing on dump cart.
(duration) ..... yrs. ..... mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.
(Signed) H W Shryock, M. D.
Mar. 28, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harrison Ida
Date of Burial: 3-29 1930

20. Undertaker: Cassedy Funeral Home
Address: Harrison Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

June 27, 1930

Dr. H.W. Shryock
Harrison, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

- -

In reference to the death certificate of:

John J. Browning who died at Harrison, Idaho on March 27, 1930
Cause of death given as "Trauma of mesentary of stomach and duodenum & jejunum---Hemorrhagic"

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO WAS INVOLVED PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Browning was hauling slabs on dump cart, seated on front of same, when as he was passing under tram way release of cart became unfastened and the weight of load lifted him up against tram with sufficient force to crush the internal vessels and viscera as described.

Yours truly,

H.W. Shryock

June 29, 1930.

RECEIVED APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69941

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
(No.)
Local Registrar's No. 2

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John August Eberhardt.

(a) Residence No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Matilda Saxon

6. DATE OF BIRTH (month, day and year) Dec. 17. 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	1 3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Eberhardt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Maria. —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Elsie M. Woodman.
(Address) Harrison. R.F. Ida

15. Filed 3-12-1930 H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to Mar. 11, 1930
that I last saw him alive on Mar. 11, 1930
and that death occurred, on the date stated above, at 9:30 A. m.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. 2 mos. + ds.
CONTRIBUTORY (Secondary) Senility - Organic
Changes in Liver + Kidneys -
(duration) + yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? —
(Signed) H W Shryock, M. D.
Mar. 12, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison.	Mar. 12 1930

20. Undertaker	Address
None — casket by Went.	Coeur D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. RECEIVED APR 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lalah

City of Genesee Idaho

Registration District No. 62

Primary Registration District No. 2142

(No. ..... St.)

File No. 69942

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Christian Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1847 (Year)

7. AGE: 83 Yrs. ..... Mos. 2 ds. 18

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Denmark.

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John G. Luedke

(Address) Genesee Idaho

15. Filed 3-12- 1930

W. H. Ehlen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1930 (Year) 10 0a

17. I HEREBY CERTIFY, That I attended deceased from March 8 1930, to March 12 1930 that I last saw her alive on March 11 1930, and that death occurred on the date stated above, at 5 13/4 M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Senility.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Walter A. Bray M. D.

3/12 1930 (Address) Uniontown Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Genesee Idaho

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho

DATE OF BURIAL: 3/14 1930

20. UNDERTAKER: Brower - Warren Co.

ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC... APR 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 69943

PLACE OF DEATH

County of Latah

City of Troy Ida

CERTIFICATE OF DEATH

Registration District No. 64

Primary Registration District No. 2144

(No. Troy Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Elwin Nelson

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years | Months | Days | If LESS than 1 day, 6 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Troy Hospital

PARENTS

10 NAME OF FATHER: Theodore Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Troy Ida

12 MAIDEN NAME OF MOTHER: Lillian Beckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Troy

14 Informant: Theodore Nelson

(Address): Troy Ida.

15 Filed April 3, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Apr. (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2, 1930, to Apr. 2, 1930, that I last saw him alive on Apr 2, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. A. Meyer M. D.

Apr 3, 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Little Bear Ridge cem

Date of Burial: April 3 1930

20. Undertaker: John J. Pickerd

Address: Troy Ida

RECE[illegible] MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69944

PLACE OF DEATH

County of Latah
City of Potlatch

Registration District No.
Primary Registration District No.
(No. Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

60 B

2. FULL NAME John Nelson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 5 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER H. Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Mattie Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant H. Nelson
(Address) Farmington Wash

15. Filed March 21 1930 D. Jno. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9th, 1930, to March 19th, 1930
that I last saw him alive on March 19th, 1930
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:

Toxic Goitre

(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary) Secondary Hemorrhage
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of March 18th
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) F. C. Gibson, M. D.
3/21, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Garfield Wash	Mar 21 1930
20. Undertaker	Address
J. M. Irwin	Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RE MAR 24 1930

DO NOT WRITE IN THIS SPACE
State File No. 69945

PLACE OF DEATH
County of Latah
City of Pullman

Registration District No. 652
Primary Registration District No. 2145
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

100a

2. FULL NAME Betty Joe Nagle

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 22 - 1929

7. AGE

Years	Months	Days	If LESS than 1 day,
4	3	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER J. L Nagle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Dakota

12. MAIDEN NAME OF MOTHER Emma Walvreaten

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant J L Nagle
(Address) Palouse Wash.

15. Filed March 11th, 1930 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 10th, 1930
that I last saw her alive on March 10th, 1930
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Serous Meningitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J W Thompson, M. D.
3/11, 1930 (Address) Pullman

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash	Mar 12 1930

20. Undertaker Address
J M Irwin Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69946

PLACE OF DEATH MAR 24 1930
County of Latah
City of Palouse
Registration District No. 65
Primary Registration District No. 3145
Local Registrar's No.
(No. Western Hospital Association Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucelia Gregory

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 3-1852

7. AGE: Years 77 | Months 7 | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ontario Canada

PARENTS

10. NAME OF FATHER: Nelson Tibbits
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: B. E. Gregory
(Address): Manor Yakima Wash.

15. Filed March 15th 1930 — J. A. Thompson, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 1930, to March 14- 1930
that I last saw her alive on March 13- 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings.
(Signed) F. C. Gibson, M. D.
19 (Address) Pottatch Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wenatchee Wash.
Date of Burial: March 1930

20. Undertaker: L. H. Irwin. Palouse Wash.
Address

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAR 24 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6994

Registered No.

1. PLACE OF DEATH

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles. Leroy. Hughes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Single.

6. DATE OF BIRTH: March. (Month) 7th (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 2. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Potlatch Idaho.

10. NAME OF FATHER: Charles. Hughes.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Olga. Hardy.

13. BIRTHPLACE OF MOTHER (State or Country): Geneva. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Charles. Hughes.
(Address): Palouse.

15. Filed March 9 1930 D. Jos. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

1610

16. DATE OF DEATH: March. (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March. 7th 1930, to March. 8th 1930, that I last saw him alive on March 8th 1930, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth from no Known. Cause

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Max. H. Hancher. M. D.

3/8/1930 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ✓

Former or usual residence ✓

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Palouse.	March 10th 1930

20. UNDERTAKER	ADDRESS
E. Irwin.	Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6948

PLACE OF DEATH
County of Latah
City of Juliaetta

Registration District No. 63
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Eliza Jane Grossclose

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Albert Grossclose

6 DATE OF BIRTH (month, day and year) Dec. 30 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	3	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ceres, Bland Co. Virginia

PARENTS
10 NAME OF FATHER Joseph Grossclose
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ceres, Bland Co. Virginia
12 MAIDEN NAME OF MOTHER Elizabeth Peebles
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ceres, Bland Co. Va.

14 Informant Wm J. Grossclose
(Address) Kendrick, Ida.

15 Filed Feb 28, 1930 B. H. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Feb. 23, 1930, that I last saw her alive on Feb. 22, 1930, and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma Many yrs. developing

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) B. H. Nesbit M. D.
Feb. 28 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Fir Ridge Cemetery	Mar 1 1930
20. Undertaker John J. Pickard	Address Troy Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6949

PLACE OF DEATH
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No.
Local Registrar's No.

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Eldringhoff

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Osage Co. Missouri

PARENTS

10. NAME OF FATHER Joseph Eldringhoff
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Senna Peters
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. D. Hunter
(Address) Rock Ida

15. Filed Mar 3, 1930 B. F. Nesbit
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to Mar. 2, 1930
that I last saw him alive on March 1, 1930
and that death occurred, on the date stated above, at 1 p. m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease
several (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) A recent attack of influenza (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Fields, M. D.
Mar. 2, 1930. (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
White Church, Mo.	

20. Undertaker	Address
John J Pickard	Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69950

PLACE OF DEATH
County of Lewis
City of Winchester
Registration District No. 60
Primary Registration District No. 2129
Local Registrar's No. 4
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1084

2. FULL NAME David Adams

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester Ida

PARENTS

10. NAME OF FATHER Arthur L. Adams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Ula Roseborough
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Arthur L. Adams
(Address) Winchester Ida

15. Filed 3/18, 1930 R. G. Dunlap
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 11, 1930
that I last saw him alive on March 11, 1930
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Exam.
(Signed) Ralph M. Alley M. D.
March 11, 1930 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Winchester Ida	3/12 1930
20. Undertaker	Address
Archer & Adams	Winchester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69951

159B

PLACE OF DEATH

County of Lewis
City of Craigmont R. F. D.

Registration District No. 60
Primary Registration District No. 2179
Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Delores Agnes Meek

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 5 1930

7. AGE — Years — Months — Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewis Co. Ida

PARENTS

10. NAME OF FATHER Stephen Meek

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewis Co. Idaho

12. MAIDEN NAME OF MOTHER Kathaleen Josephine Lacy Foden
Kathaleen Josephine Lacy Foden

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Slate Meek Hill
(Address)

15. Filed 3/15, 1930 R. E. Dewey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 16, 1930
that I last saw her alive on March 14, 1930
and that death occurred, on the date stated above, at 8:10 P. m.
The CAUSE OF DEATH* was as follows:
Congenital cardiac defect
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? examination
(Signed) R. E. Dewey M. D.
3/15, 1930 (Address) Sequent

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Fletcher Cemetery Craigmont Ida
Date of Burial 3-17-1930

20. Undertaker Charles Hill
Address Sequent R. F. D.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69952

PLACE OF DEATH

County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
(No. Burdett Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

101a

2. FULL NAME Frank William Kuka

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Kuka

6. DATE OF BIRTH (month, day and year) Mar 23 1879

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
50	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Watertown Minn

PARENTS

10. NAME OF FATHER Joseph Kuka
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Francis Janikula
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Emma Kuka
(Address)

15. Filed Mch 15 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 14, 1930
that I last saw him alive on March 14, 19..
and that death occurred, on the date stated above, at 9.25 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) L. E. Barrett, M. D.
Mar 15, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Cemetery
Date of Burial: Mar 17 1930

20. Undertaker: C E Hickok
Address: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69953

Registration District No. 16
Primary Registration District No. 1016
Local Registrar's No. 5

PLACE OF DEATH

County of Lincoln
City of Shoshone
(No. Burdett Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel G. L. Seifert
(a) Residence. No. Shoshone St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) July 16, 1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	7	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Saloon.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Harrisburg Penn.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Dr F. E. Bassett
(Address) Shoshone

15. Filed March 19, 30 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to March 13 1930
that I last saw him alive on March 13, 1930
and that death occurred, on the date stated above, at 8 30 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 26 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy. Exam.
(Signed) F. E. Bassett, M. D.
March 14, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrisburg Pa	19
20. Undertaker	Address
B E Hickok	Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69954

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 76
Primary Registration District No. 1016
(No. McFall Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

1010

2. FULL NAME Mathew McFall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle McFall

6. DATE OF BIRTH (month, day and year) Aug 29 1849

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Proprietor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hamilton Canada

PARENTS

10. NAME OF FATHER Wm McFall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hamilton Canada
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Isabelle McFall
(Address)

15. Filed Mch 5, 1930 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to Mar 3, 1930
that I last saw him alive on March 3, 1930
and that death occurred, on the date stated above, at 8 00 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Pliny Exam
(Signed) F. E. Barrett, M. D.
March 4, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Ida — Date of Burial: Mar 6 1930

20. Undertaker: C E Hickok — Address: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 60955

PLACE OF DEATH

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 16

(No. Rexburg Gen Hosp)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Shail

(a) Residence. No. Rexburg Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~XXXXX~~ Jane Shail

6. DATE OF BIRTH (month, day and year) April 25, 1874

7. AGE: Years 55, Months 11, Days 21. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: George A Shail

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Zuriah Hallam

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs, James Shail

(Address) Rexburg, Idaho,

15. Filed 4/5, 1930 J Lyoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 4, 1930

that I last saw him alive on April 4, 1930

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH was as follows:

Accidental Giant Powder Explosion
While Blasting Lava Rock
(1) Fractured Skull (Crushed)
(2) Lacerated Brain (duration) yrs. mos. ds.
(3) Compound fracture left humerus
(4) Face & Hands powder burned
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.

4-15-30, 19 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg, Idaho, Date of Burial: 4/6/30 19

20. Undertaker: A B Eckersell Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69956

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME Sarah Ann Green

129

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male
4. COLOR OR RACE: white
5. ~~Single, Married~~, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Thomas Green

6. DATE OF BIRTH (month, day and year): Dec. 23/1860

7. AGE: Years 69, Months 3, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): St Louis Mo

PARENTS

10. NAME OF FATHER: Thomas Mander
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Marsah Leishman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Wm. Beattie
(Address): Rexburg R.F.D.

15. Filed 3/29, 1930 J. Rezorng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Mar 27, 1930
that I last saw her alive on Mar. 27, 1930
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? usual tests
(Signed) W. Sutherland, M. D.
3-28, 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grantsville Cemetary
Date of Burial: Mar 31 1930

20. Undertaker: [illegible]
Address: [illegible]

FORM V. S. No. 5-25 M. 1-19.

RECEIVED APR 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 69957

Local Registrar's No. 10

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2013

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Betty Lou Mahoney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov. 17 (Month) (Day) 1922 (Year)

7. AGE: 7 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF Father: William Eugene Mahoney

11. BIRTHPLACE OF FATHER (State or Country): Albion Idaho

12. MAIDEN NAME OF MOTHER: Jennie Alley

13. BIRTHPLACE OF MOTHER (State or Country): Elba, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Mahoney

(Address) Albion Idaho

15.

Filed 4 — 2 1930 E. B. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 28 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1930, to March 28 1930, that I last saw her alive on March 28 1930, and that death occurred on the date stated above, at 2-20 AM.

The CAUSE OF DEATH* was as follows:

Chronic Brights disease

(Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Cystitis

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Leland Fraser M. D.

4-2-1930 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho — DATE OF BURIAL: March 30 1930

20. UNDERTAKER: L. E. Johnson — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69958

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2016
Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Charlotte Surrage

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W Surrage

6. DATE OF BIRTH (month, day and year) June 24, 1895

7. AGE Years 34 Months 8 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Weber Co Utah

PARENTS
10. NAME OF FATHER John Sheppard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jennett Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant C W Surrage
(Address) Heyburn Ida

15. Filed 4-2, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 23 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930, to Mar 23, 1930
that I last saw her alive on Mar-22, 1930
and that death occurred, on the date stated above, at 9: A. m.
The CAUSE OF DEATH* was as follows:
- Heart paralysis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) - Shock-post operative (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Mar 20-30
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) Dr. H. Cooper, M. D.
Mar 31, 1930 (Address) Burley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Heyburn Ida — Date of Burial Mar. 26 1930

20. Undertaker L. E. Johnson — Address Burley

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69960

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 8

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME John C Breshears

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~ (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 1 1855

7. AGE Years 75 Months Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Mexico
(State or country) Missouri

PARENTS
10. NAME OF FATHER John Breshear
11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)
12. MAIDEN NAME OF MOTHER Nancy Riggins
13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)

14. Informant Menerva E Sanders
(Address) Hellsburgh Calanfornia

15. Filed 3-31, 1930 R.R. 1 #153
E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to March 29, 1930
that I last saw him alive on March 29, 1930
and that death occurred, on the date stated above, at 6 30 p m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia bilateral — as a complication of influenza
..... (duration) ..... yrs. 1 mos. 24 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Burley, Idaho
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19..... (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mexico Missouri
Date of Burial 1930

20. Undertaker W. G. Goodman
Address Burley Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69961

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 9 6
Primary Registration District No. 1009
(No. 134)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Emma J. Rice

(a) Residence. No. St. Joseph Hospital St. Grangeville Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bailey F. Rice

6. DATE OF BIRTH (month, day and year) Dec 27-1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Freedom Idaho

PARENTS

10. NAME OF FATHER Geo. Albine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Alma Cully
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Bailey F. Rice
(Address) Grangeville Idaho

15. Filed Jun 1, 1930 Susan Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1930, to Feb 24th, 1930
that I last saw her alive on Feb 24th, 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

General Peritonitis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Appendicitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Grangeville Idaho
Did an operation precede death? Yes Date of Feb 21st 30
Was there an autopsy? No
What test confirmed diagnosis? Pus in abdomen
(Signed) W. C. Emerson M. D.
3/31, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Freedom Ida	3/26 1930

20. Undertaker Brown-Wann Co Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE
State File No. 69962

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Samuel Olson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE 61 Years — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Frank Willard
(Address) Lewiston, Idaho

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929 to Feb. 13, 1930
that I last saw him alive on Feb. 13, 1930
and that death occurred, on the date stated above, at 5-30 a.m.
The CAUSE OF DEATH* was as follows: Interest & Cleroses

..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J M Lyle, M. D.
2/14, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 9/15 1930

20. Undertaker Brower-Wann & Lewiston Idaho — Address

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 89963

PLACE OF DEATH
County of Nezperce
City of Lewiston,

Registration District No.
Primary Registration District No. 96
(No. St Josephs 1009)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 480

2. FULL NAME James Boggan

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Gollick

6. DATE OF BIRTH (month, day and year) Oct. 10, 1880

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49	3	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Anatone, Wash.

PARENTS

10. NAME OF FATHER James N. Boggan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Anson Co. N.C.

12. MAIDEN NAME OF MOTHER Henryetta Barker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jackson, Co. Mo

14. Informant Mrs Minnie Boggan (Wife)
(Address) Anatone, Wash.

15. Filed Jan 1, 1930 Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Feb 3, 1930
that I last saw him alive on Feb 2, 1930
and that death occurred, on the date stated above, at 12:30 a m.
The CAUSE OF DEATH* was as follows:
Endocarditis & myocarditis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Anatone Wash
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Paul W Johnson M. D.
Feb 8, 1930 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Wash	2/6/30 19

20. Undertaker H.R. Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 60964

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1012

2. FULL NAME Harry Edgar Ostrander

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Francis E Northrup

6. DATE OF BIRTH (month, day and year) March 19, 1983

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boydsmills Penn

PARENTS

10. NAME OF FATHER Levi R. Ostrander
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ellenville N.Y.
12. MAIDEN NAME OF MOTHER Susan B. Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs. Francis E Ostrander (Wife)
(Address) Lewiston, Ida.

15. Filed Jan 1, 1930. Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to Feb 7, 1930
that I last saw him alive on Feb 7, 1930
and that death occurred, on the date stated above, at 11:30 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Acute.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Cause

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms.

(Signed) E. L. White, M. D.
2-8, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Wash	2/9/30 19

20. Undertaker H.R. Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Mrs Mahan

DO NOT WRITE IN THIS SPACE
State File No. 69965

PLACE OF DEATH
County of Nez Perce
City of Near Waha

Registration District No. 95
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

91a

2. FULL NAME William Gaiser

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emily Gaiser

6. DATE OF BIRTH (month, day and year): 10/5/1869

7. AGE: 60 Years, Months 4, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS
10. NAME OF FATHER: Wm Gaiser
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Barbara —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. Wm Gaiser
(Address): Waha, Idaho

15. Filed Jan 1, 1930. Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31st, 1930, to Feb. 8th, 1930
that I last saw him alive on Feb. 7th, 1930
and that death occurred, on the date stated above, at 3 — P. m.
The CAUSE OF DEATH* was as follows:
Aneurism: Arch Aorta.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. F. McNeahan, M. D.
2/12, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho
Date of Burial: 2/11 1930

20. Undertaker: Brooer-Wann
Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Braddock

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69966

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. 712 — N St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

111a

2. FULL NAME Mark Thompson
(a) Residence. No. 712 — N. Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruby H. Thompson

6. DATE OF BIRTH (month, day and year) May 22 — 1868.

7. AGE Years 61 Months 8 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Isaac Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland
12. MAIDEN NAME OF MOTHER Susan Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Mrs Mark Thompson
(Address) Lewiston Idaho

15. Filed Jan 1, 1930. Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb 8, 1930
that I last saw him alive on Feb 8, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Perforated Gastric ulcer
(Refused operation)
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) ulcer stomach
..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E G Braddock, M. D.
2/10, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho — Date of Burial 2/12 1930

20. Undertaker Brower-Wann — Address Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69967

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary J. Taylor

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho.

PARENTS

10. NAME OF FATHER Dan J. Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Omaha Neb.
12. MAIDEN NAME OF MOTHER Nora Carpenter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Genesee Idaho.

14. Informant Mary J. Taylor
(Address)

15. Filed Jan 1, 1930 Susan E Brue Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Feb 12, 1930, that I last saw him alive on Feb 11, 1930, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:
Pulmonary Intercalosis
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) L. T. Scott, M. D.
Feb 19, 1930 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Idaho	

20. Undertaker Vassar Bros Address Lewiston

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69968

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 318 — 1st Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Charles Ainsworth Hastings

(a) Residence. No. 318 — 1st Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 2/2/1856

7. AGE Years 74 Months — Days 19 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cambridge Mass.

PARENTS
10. NAME OF FATHER — Hastings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass
12. MAIDEN NAME OF MOTHER Mary Tuttle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass.

14. Informant L. A. Hastings
(Address) San Diego Calif.

15. Filed Jan 1, 1930. Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929, to Feb. 21, 1930
that I last saw him alive on Feb. 21, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* ~~was as follows:~~
General Arteriosclerosis
appoplexy.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
Several yrs (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) L B Stockelage, M. D.
2/22, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho. Date of Burial: 2/23 1930

20. Undertaker: Brower-Wann Co Address: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Habel

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69969

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Chas Miller
(a) Residence. No. Lewiston Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 13 - 1877
7. AGE Years 52 Months 3 Days 27 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plummer & Tinner
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer -
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Alfred Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Isabelle Cleland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs D D Hoffer
(Address) Lewiston Ida

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1930, to Feb. 9, 1930
that I last saw him alive on Feb. 9, 1930
and that death occurred, on the date stated above, at 7 30 a. m.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
(duration) 1 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Primary
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) William H Habel, M. D.
Feb. 10, 1930, (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial Feb 10 1930
20. Undertaker Vassar Mortuary
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6997G

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Kenneth Elsworth Closson.

(a) Residence. No. 1602 Carson Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 1st 1909

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	21	—	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS

10. NAME OF FATHER Elmer E. Closson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Helen Marquardt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chicago Illinois

14. Informant Mrs. E. E. Closson
(Address) City.

15. Filed Jan 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930 to Feb 19, 1930
that I last saw him alive on Feb 19, 1930
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis
Parenchymatous (duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Heart Block
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Laboratory tests
(Signed) O. E. Closson, M. D.
, 19 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	2/22 1930
20. Undertaker	**Address**
Bower-Mann Co.	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69971

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

129

2. FULL NAME Gulick O. Grover
(a) Residence. No. Lewiston Orchard St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Grover Deceased

6. DATE OF BIRTH (month, day and year): March 3rd 1852

7. AGE: Years 77 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer): Fruit Grower
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bergen, Norway

PARENTS
10. NAME OF FATHER: Ob Grover
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.
12. MAIDEN NAME OF MOTHER: Martha ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway.

14. Informant: Mrs. Clinton Smith
(Address) Lewiston Idaho.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Feb 21, 1930
that I last saw him alive on Feb 15, 1930
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
..... (duration) years yrs. mos. ds.
CONTRIBUTORY (Secondary) .....
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Paul W Johnson, M. D.
Feb 25 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Deary Idaho
Date of Burial: 2/24 1930

20. Undertaker: Brower Wame Co
Address: Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69972

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 409 1/2 Main St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

170

2. FULL NAME Martin Le Smith

(a) Residence. No. Butler Bldg. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 18 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Railroad
(b) General nature of industry, business, or establishment in which employed (or employer) man.
(c) Name of employer N. P. Ry.

9. BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10. NAME OF FATHER Henry Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Amanda Watson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Chas Smith
(Address) Entiat Wn.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Gun Shot wound in Head — Suicide
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Bowers Coroner M. D.
2/20, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	2/21, 1930

20. Undertaker	Address
Bowers-Hane Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 31

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69974

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. ~~St Joseph~~ Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Chas. A. Dickinson

(a) Residence. No. St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 15 - 1857

7. AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Prospector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Solemen Dickinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Clara Stiles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N Y

14. Informant B. A. Dickinson
(Address) Van Nuys California

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Jan~~ Feb 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/2-30, 19, to 2/13-30, 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertrophy of prostate
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rouse M.D. M.D.
, 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial Feb 18 1930

20. Undertaker Vassar Mortuary
Address Lewiston

RECEIVED MAR 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69975

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95
Primary Registration District No. 1009
(No. Lewiston Orchards)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

165

2. FULL NAME Mrs Antonia Muscato 95
(a) Residence. No. Lewiston Orchards 1009 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Antonio Muscato

6. DATE OF BIRTH (month, day and year) Nov. 20th 884

7. AGE Years 45 Months 3 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS
10. NAME OF FATHER De Francesco fu Giuseppe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Vincenzo Tumasela
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant A. Muscato
(Address) Lewiston Orchards

15. Filed Jan 1, 1930 Susan E Brue Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~2-21-30~~ 2 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-21-'30, 19, to 2-24-'30, 19
that I last saw her alive on 2-24, 1930
and that death occurred, on the date stated above, at 12:10 P.m.
The CAUSE OF DEATH* was as follows:
Cardiac Asthma
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Menopause
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. J. McMahan M. D.
2-25, 1930 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 2/26 1930

20. Undertaker Vassar Mortuary Inc
Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69976

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 17
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myron A. Jones.

(a) Residence. No. Malad St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 24 30

7. AGE — Years | Months | Days | If LESS than 1 day, 4 hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad (State or country) Ida

PARENTS

10. NAME OF FATHER Milton T. Jones
11. BIRTHPLACE OF FATHER (city or town) Malad (State or Country) Ida.
12. MAIDEN NAME OF MOTHER Lama Corbridge
13. BIRTHPLACE OF MOTHER (city or town) Lewiston (State or Country) Utah

14. Informant Milton T. Jones
(Address) Malad Idaho

15. Filed 3/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 24. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to March 24, 1930
that I last saw h[illegible] alive on March 24, 1930
and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency.
4 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Kerns, M. D.
3/24, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida — Date of Burial: Mar 25 1930

20. Undertaker: J. Levy Benson — Address: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69977

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

124

2. FULL NAME Oliver Cowdry Balse
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Harriet Williams

6. DATE OF BIRTH (month, day and year) April 14-1859

7. AGE: Years 70, Months 11, Days 8; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pittsburg Penn.

PARENTS
10. NAME OF FATHER: Henry Balse
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Manchester England
12. MAIDEN NAME OF MOTHER: Sarah Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Elizabeth Burke Jones
(Address) Malad Ida

15. Filed 3/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 23 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 9, 1930, to Mch 23, 1930
that I last saw him alive on Mch 23, 1930
and that death occurred, on the date stated above, at 9:30 P m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Kerns M. D.
3/23, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John Ida — Date of Burial: Mar. 27 1930

20. Undertaker: J. Guy Benson — Address: Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69978

PLACE OF DEATH
County of Ouida
City of Malad Ida

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10

2. FULL NAME Frank Layland

(a) Residence. No. Malad Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June. 4. 1920

7. AGE Years 9 Months 9 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Malad Ida.
(State or country)

PARENTS

10. NAME OF FATHER Charles Layland

11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Stella Williams

13. BIRTHPLACE OF MOTHER (city or town) Malad Ida.
(State or Country)

14. Informant Philip Cocklington
(Address) Malad Ida

15. Filed 3/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 16, 1930
that I last saw him alive on March 16, 1930
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
Diphtheria

..... (duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? culture
(Signed) O H Mabey M. D.
3/16, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida | Date of Burial Mar. 18 1930

20. Undertaker J. Guy Berman | Address Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

PLACE OF DEATH

County of Oneida

City of Malad

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 3069

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 69979

Local Registrar's No. 14

480

2. FULL NAME Earl Robert Donnelly

(a) Residence. No. Main St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 18, 1916

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	3	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Malad (State or country) Idaho

PARENTS

10. NAME OF FATHER Robert Donnelly

11. BIRTHPLACE OF FATHER (city or town) Morgan (State or Country) Utah

12. MAIDEN NAME OF MOTHER Jessie Palmer

13. BIRTHPLACE OF MOTHER (city or town) Brigham (State or Country) Utah

14. Informant Dora Wooley

(Address) Malad Idaho

15. Filed 3/31, 1930 J. M. Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to March 15, 1930

that I last saw him alive on March 15, 1930

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism

(duration) yrs. mos. 24 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) J. M. Evans M. D.

3/15, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Cem	Mar 18 1930

20. Undertaker	Address
J. Guy Hansen	Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69980

PLACE OF DEATH

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

Local Registrar's No. 1.3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Charleen Kent.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May-19-1929

7. AGE Years | Months 9 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. John Idaho

PARENTS

10. NAME OF FATHER Daniel W. Kent.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Idaho

12. MAIDEN NAME OF MOTHER Clara M. Neilsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brigham Utah

14. Informant Daniel W. Kent
(Address) Malad Ida

15. Filed 3/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 4, 1930
that I last saw her alive on Mar 3, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) none

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [signature], M. D.

3/5, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John Ida | Date of Burial Mar 6 1930

20. Undertaker J. Guy Benson | Address Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

R MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 69999

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

48 B

2. FULL NAME Margaret Jane Buckstead

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of A Buckstead

6. DATE OF BIRTH (month, day and year) Oct 11 1861

7. AGE 68 Years | Months 3 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER J. L. Fifer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Alvira Rosiborough
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X X

14. Informant Mrs. W. B. Allison
(Address) B1 - Caldwell, Ida.

15. Filed Feb 15, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 20, 1930
that I last saw her alive on Jan 20, 1930
and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:
Valvular heart disease chr.
Chronic myocarditis.
indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Fox, M. D.
Jan. 25, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Ida. Date of Burial Jan 23 1930

20. Undertaker S. Hudson Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70000

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 4

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

88 B

2. FULL NAME John R Jewel

(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 1867

7. AGE Years: 62 Months: 11 Days: 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Silas Jewell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: X X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ~~Iowa~~ XX

14. Informant: J. H. Adair
(Address) Payette

15. Filed Feb. 15, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930 to Jan 7, 1930
that I last saw him alive on Jan 7, 1930
and that death occurred, on the date stated above during m.
The CAUSE OF DEATH* was as follows: Note of Jan 9, 1930
Valvular heart disease - myocarditis.
indefinite (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) Merrill R. Jo M. D.
Jan. 15, 1930 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette Ida
Date of Burial: Jan 14 1930

20. Undertaker: J. H. Adair
Address: Payette Ida
Paterson Furn Co

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE[illegible] MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70001

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No. .....)
(If ~~death~~ occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

100 a

2. FULL NAME Ruby E. Heide

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 29 1929

7. AGE Years | Months 1 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS
10. NAME OF FATHER Ben Heide
11. BIRTHPLACE OF FATHER (city or town) (State or Country) S. Dak
12. MAIDEN NAME OF MOTHER Lidia Bline
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Dak

14. Informant Ben Heide
(Address) Payette Ida

15. Filed Feb 15, 1930 J. B. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to ....., 19..., that I last saw her alive on Dec. 29, 1929 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Pneumonia - bronchial
..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Fox, M. D.
Jan. 4, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Ida | Date of Burial Jan 5 1930

20. Undertaker D. H. Adair Address Peterson Furn Co Payette Ida

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76002

PLACE OF DEATH
County of Payette
City of Fruitland
Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 2
(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph M Wallace

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 16 -

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
72	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER David Wallace
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Ellen Turner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dead

14. Informant Guy H Wallace
(Address) Fruitland Ida

15. Filed Feb 4 1930. J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows: Gun shot wound self inflicted

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D. N. Adair Coroner
Feb 3, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nyssa Ore — Date of Burial Feb 4 1930
20. Undertaker D N Adair — Address Peterson Furn Co Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70003

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008

Local Registrar's No. 1

48 B

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William L. Spottwood

(a) Residence. No. 9 S. 11th Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Phebe Boyd.

6. DATE OF BIRTH (month, day and year) Oct 22. 1841

7. AGE	Years	Months	Days	If LESS than 1 day,
	88	2	22	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana Penn.

PARENTS

10. NAME OF FATHER William Spottwood.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Martha Lucas.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant J. C. Woodward
(Address) Payette Idaho

15. Filed Jan 15, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Jan 13, 1930
that I last saw him alive on Jan 13, 1930
and that death occurred, on the date stated above, at 10 m. a. m.
The CAUSE OF DEATH* was as follows:
arterio-sclerosis; myocarditis

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Merrill R. Loy, M. D.
Jan 13, 1930 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Ida.	Jan 15 1930
20. Undertaker	Address
Glenn C Landen.	Payette. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70004

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power

City of American Fall

Registration District No. 23

Primary Registration District No. 2072

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

505-B

2. FULL NAME Donald Meisenheimer

(a) Residence. No. Misenhimer St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Mch 23-1930

7 AGE: Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) American Falls Idaho

PARENTS

10 NAME OF FATHER Harold Clifton Meisenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Lena Krugg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant H. C. Misenhimer
(Address)

15 Filed Mch 31, 1930 Gwenen Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mch (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mch 23, 1930, to Mch 23, 1930, that I last saw h alive on Mch 23, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Dont Know

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

— (duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

, 19 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Amer. Falls

Date of Burial 1930

20. Undertaker: Family

Address

RECEIVED APR 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of Power

City of Am Falls

CERTIFICATE OF DEATH

Registration District No. 25

Primary Registration District No. 2072

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70005

Local Registrar's No. 5

88 (B)

2. FULL NAME Therese Neu

(a) Residence. No. American Falls, Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Neu

6 DATE OF BIRTH (month, day and year): Aug 12th 1884

7 AGE: Years 46 | Months 10 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: John Deeg Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Katherine Stickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jacob Neu

(Address) American Falls, Idaho

15 Filed 3-24, 1930 Genevieve Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March 23rd 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Mch 23, 1930, that I last saw her alive on Mch 23, 1930, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis with dilatation of heart operated for duodenal ulcer on Mch 14 1930 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mch 14 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. F. Schultz, M. D.

3/24/30, 19 (Address) Am Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I.O.O.F Cemetary

Date of Burial: 3/26th 1930

20. Undertaker: A W Davis

Address: American Falls, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70006

Registration District No. 70
Primary Registration District No. 1911
Local Registrar's No. 18

PLACE OF DEATH
County of Shoshone
City of Burke,
(No. Tamarack Mine)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter Johnson.
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 38 | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden.

14. Informant: Tamarack Mining Co.
(Address) Wallace, Idaho
15. Filed Feb 22, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to Feb 19, 1930
that I last saw him alive on Feb 19, 1930
and that death occurred, on the date stated above, at 3:40 p.m.
The CAUSE OF DEATH* was as follows:
Fractured Skull & Crushed body &
Legs Fall down Rock Chute
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
Accidental
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. H. Hoffeldt, M.D.
2/19/30 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho — Date of Burial: Feb 22 1930
20. Undertaker: J. A. Bucs — Address: Wallace, Idaho
Ward Undertaking Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70007

PLACE OF DEATH
County of Shoshone
City of Near Kellogg

Registration District No. 70
Primary Registration District No. 1011
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

86

2. FULL NAME Charles Warren Bush
(a) Residence. No. Sunshine Mine St. Near Kellogg
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Florence Bush

6. DATE OF BIRTH (month, day and year) June 5 - 1895

7. AGE Years 34 Months 6 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sunshine Mine

9. BIRTHPLACE (city or town) (State or country) Moss

PARENTS
10. NAME OF FATHER Eli Bush
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc.

14. Informant Florence Bush
(Address) Kellogg. Idaho.

15. Filed Feb 28, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 8 05 a m.
The CAUSE OF DEATH* was as follows:
Body crushed & broken in fall down shaft of Sunshine mine accidental (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) H. C. Mowery Coroner M. D.
2/24, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg ~~Wallace~~ Idaho. Date of Burial ~~Feb 28~~ 1930

20. Undertaker J. A. Burke Ward Und Co. Address Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70008

Registration District No. 20
Primary Registration District No. 1011
Local Registrar's No. 19

1916

PLACE OF DEATH

County of Shoshone
City of Near Kellogg.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver Burns.

(a) Residence. No. Wallace, Idaho. St. Near Kellogg.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1908

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
22			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Sunshine Mng Co.

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Geo Burns
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Lillie Lockard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs A Burns
(Address) Wallace Idaho.

15. Filed Feb 26, 1930 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 8:05 A m.
The CAUSE OF DEATH was as follows:
Body Crushed & Broken by fall of cover Shaft Shaft age same as deceased
(duration) 2 hours
CONTRIBUTORY (Secondary) none
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What confirmed diagnosis? .....
(Signed) H. O. Mowery Coroner
2/24, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Feb 26 1930
20. Undertaker J. A. Buser Ward Und Co.	Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70009

PLACE OF DEATH
County of Shoshone
City of Burke

Registration District No. 70
Primary Registration District No. 1011
(No. Tamarack Mine.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

186

2. FULL NAME John Nels Lundberg
(a) Residence. No. Spokane St. Burke Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Lundberg.
6. DATE OF BIRTH (month, day and year) Aug 28 - 1863
7. AGE 66 Years 6 Months 21 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Tamarack Mine
9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Miss Ruth Lundberg.
(Address) Burke, Idaho.
15. Filed Feb 20, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 2 3/4 m.
The CAUSE OF DEATH* was as follows: Fractured Skull & neck
(duration) Instant yrs. mos. ds.
CONTRIBUTORY (Secondary) Fall down Rock Chute
Accidental (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Mowery Jorong
2/19, 1930. (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial Feb 20 1930
20. Undertaker J. A. Bever Ward Und Co. Address Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70010

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

162

2. FULL NAME Marguerite Louise Wright
(a) Residence. No. 207 Stationane St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24-1930

7. AGE Years Months 1 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Idaho
(State or country)

PARENTS
10. NAME OF FATHER Herbert Wright
11. BIRTHPLACE OF FATHER (city or town) La Grand Ore
(State or Country)
12. MAIDEN NAME OF MOTHER Myrtle Caldwell
13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Herbert Wright
(Address) Kellogg Idaho

15. Filed 3/31/30, 19 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-23, 1930, to 3-23-, 1930
that I last saw her alive on 3-23-, 1930
and that death occurred, on the date stated above, at 4p. m.
The CAUSE OF DEATH* was as follows:
Acidosis,
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) none known
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Tw Laraway M. D.
3-31-, 1930. (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Idaho
Date of Burial Mar 25 1930

20. Undertaker R. L. Gant
Address Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70011

PLACE OF DEATH
County of Shoshone
City of Near Kingston
Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 19
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME Johana Johnson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Adfred Johnson

6. DATE OF BIRTH (month, day and year) Apr 12, 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Mr. Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER No inf.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Jno Gregory
(Address) Kingston, Idaho

15. Filed 3/30/30, 19 Mrs. Ethel B. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 4, 1930
that I last saw h alive on March 2, 1930
and that death occurred, on the date stated above, at 10.30 A m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Mason, M. D.
March 13, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kingston, Idaho	March 8, 1930

20. Undertaker	Address
M. C. Thornhill	Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70012

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Black Lake Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

2. FULL NAME Gustaf Erickson
(a) Residence. No. Mullan Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 6 1891

7. AGE: Years 48, Months 8, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer): Lead Mines
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓ ✓
12. MAIDEN NAME OF MOTHER: ✓ ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓ ✓

14. Informant: Sam Hammer
(Address) Mullan Idaho

15. Filed 2-26, 1930 G. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 24 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) R. D. Dooney Coroner, M. D.
2/26, 1930 (Address) Coe d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Wallace, Idaho. Date of Burial: Feby 26 1930

20. Undertaker: B. G. Worstell Address: Wallace

FORM V. S. No. 5-A-25M. 1-19. REC'D MAR 18 1930 **CERTIFICATE OF DEATH** Dr Bean

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70013
Local Registrar's No. 16

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. King St St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Meida Richardson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: May (Month) 16 (Day) 1854 (Year)

7. AGE: 75 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF Father: — Warren

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: ✓ ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓ ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Richardson
(Address) Wallace, Idaho

15. Filed Feb 16 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH: February (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 10 1930, to Feby 14 1930, that I last saw her alive on Feby 13 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia R. lower lobe

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.
7/15 1930 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Feby 17 1930

20. UNDERTAKER: B G Worstell
ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19

RECEIVED MAR 18 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70014

Local Registrar's No. 15

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Providence Hosp. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Champ Castleton Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: March (Month) 3rd (Day) 1912 (Year)

7. AGE: 17 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF Father: Mason Lowell Butler

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mary Violet Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elevyn Louise Pointer
(Address) Rosalia Wash

15. Filed Feb 16 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 9 1930 to Febr 14 1930, that I last saw him alive on Febr 13 1930 and that death occurred on the date stated above, at 3:35 A.M.

The CAUSE OF DEATH* was as follows:

Alph Coemid

(Duration) ..... yrs. ..... mos. 4-5 ds.

Contributory (Secondary) Ferrhunter Rupture

Appendicitis (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Drs Moweth M. D.

3/14 1930 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: 2/16 1930

20. UNDERTAKER: B G Worstell

ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

MAR 18 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

File No. 7001 5
Registered No. 14

1. PLACE OF DEATH.
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L. Murry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
1 (Month) 12 (Day) 1885 (Year)

7. AGE
45 Yrs. 0 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Penn "Allentown"

10. NAME OF FATHER John Murry.

11. BIRTHPLACE OF FATHER
(State or Country) Penn

12. MAIDEN NAME OF MOTHER Alice Murry.

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. M. Regan
(Address) Shoshone County Inquest

15.
Filed Feb 6 1930
L. K. Quigley
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
1 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-12- 1930, to 1-30- 1930, that I last saw him alive on 1-30- 1930, and that death occured on the date stated above, at 3 10 M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) James R Dean M. D.

19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 18 days. In the State 0 yrs. 3 mos. days

Where was disease contracted if not at place of death? Not Known

Former or usual residence Wallace Ida.

19. PLACE OF BURIAL OR REMOVAL: [illegible]

DATE OF BURIAL: Feb 2 1930

20. UNDERTAKER: [illegible]

ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70016

PLACE OF DEATH

County of Shoshone
City of Wallace
Registration District No. 7c
Primary Registration District No. 10-1
Local Registrar's No. 15
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. **FULL NAME** Stephano Condé.

(a) Residence. No. Burke Road. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Rosa Condé.

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Tamarack Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10. NAME OF FATHER Not Known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy.
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy.

14. Informant James Morese.
(Address) Wallace, Idaho.

15. Filed Feb 6, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Not Known 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Jan 15, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Tumor of Lungs
Found dead in cabin
Hab. Drunkard
Acute Alcoholism (duration) hrs. min.
CONTRIBUTORY (Secondary) TB Pulmonary (duration) several mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. C. Roberts Coroner M. D.
Feb 4, 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	Feb 6 1930

20. Undertaker J. G. Boyer Address Wallace, Idaho
Ward Und. Co.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70017

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No.) 100a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Elmer Le Roy Thompson
(a) Residence. No. Burke - Idaho St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan 7 - 1928
7. AGE: Years 2, Months 0, Days 24. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Burke, Idaho

PARENTS
10. NAME OF FATHER Elmer Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Dakota.
12. MAIDEN NAME OF MOTHER Ellis Finn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Elmer Thompson
(Address) Burke, Idaho.
15. Filed Feb 5, 1930 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 1, 1930
that I last saw him alive on Feb 1, 1930
and that death occurred, on the date stated above, at 9:25 P.m.
The CAUSE OF DEATH* was as follows: Broncho Pneumonia
(duration) yrs. Several mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Des Mowery, M. D.
2/3, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho. Date of Burial: Feb 5 1930
20. Undertaker: J. A. Bever, Ward Und. Co. Address: Wallace, Idaho.

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76018

PLACE OF DEATH
County of Shoshone
City of Mace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

100a

2. FULL NAME Curtis M. Killian
(a) Residence. No. Mace, Idaho St. Mace, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 22 - 1913

7. AGE Years 17 Months 0 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hecla Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Black Bear Idaho.

PARENTS
10. NAME OF FATHER Luther Killian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina.
12. MAIDEN NAME OF MOTHER Mildred Dowling.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Luther Killian
(Address) Mace, Idaho.

15. Filed Feb 4, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930 to Feb 1, 1930
that I last saw him alive on Feb 1, 1930
and that death occurred, on the date stated above, at 1:10 p.m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
all lobes both lungs
(duration) yrs. mos. 5-6 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. Severa ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Drs Mowery M. D.
2/3, 1930 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Feb 4 1930

20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Ida.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70019

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Hughes

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) March 31/30

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			Premature	15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER Hughes
11. BIRTHPLACE OF FATHER (city or town) Mich"
(State or Country)
12. MAIDEN NAME OF MOTHER X
13. BIRTHPLACE OF MOTHER (city or town) X
(State or Country)

14. Informant Hughes
(Address) Filer Idaho

15. Filed April 5th, 1930. Elizabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 a.m. Mar. 31 - 1930, to 3:15 a.m. March 31-30
that I last saw him alive on March 31 -, 1930
and that death occurred, on the date stated above, at 3:15 a.m.
The CAUSE OF DEATH* was as follows:

Premature
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Jolting in auto ride.
(duration) yrs 12 Hours mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) F. A. Dwight, M. D.
March 31, 1930 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer	April 1 1930

20. Undertaker F. E. Drake — Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70020

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH

County of Twin Falls
City of Filer Ida
(No. ..... 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elvira Knapp

(a) Residence. No. Filer St. Salgander
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 17 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	2	13	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington
12. MAIDEN NAME OF MOTHER McRoy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant E. K. Knapp
(Address) Filer

15. Filed April 7th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to March 30 1930
that I last saw h.. alive on March 29, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Senility (Arterio Sclerosis general)
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Toxemia intestinal
(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Duncan L. Alexander, M. D.
3/31/30 19..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	April 2 1930

20. Undertaker F. C. Drake — Address Twin Falls

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20021

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

71B

2. FULL NAME Clara Norris

(a) Residence. No. 2½ miles E of Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Quincy Norris

6. DATE OF BIRTH (month, day and year) March 13 - 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Homework
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Randall Kan.

PARENTS

10. NAME OF FATHER Charles W. Harford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Lephia Ella Peabody
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Quincy Norris
(Address) Twin Falls R.R.

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 3 (Day) 30 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from 3-27, 1930, to 3-30, 1930
that I last saw her alive on 3-30-~~30~~, 1930
and that death occurred, on the date stated above, at 6A m.
The CAUSE OF DEATH* was as follows:

Cerebro spinal Meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Cultare spinal fluid

(Signed) Chas. R. Scott, M. D.
4-2, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Twin Falls Ida	4-3 1930
20. Undertaker	Address
White Mortuary	Twin Falls Idaho

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70022

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

151

2. FULL NAME J. A. Tyler
(a) Residence. No. 293 Adams Str St. Dr Coughlin
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 29 / 1858
7. AGE Years 72 Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah
PARENTS
10. NAME OF FATHER DeWitt Tyler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) NY
12. MAIDEN NAME OF MOTHER Sarrah Pratt Tyler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) NY
14. Informant Mrs Laura Tyler
(Address) Rockland Ida
15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH 1-30

16. DATE OF DEATH March 29 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 29, 1930
that I last saw him alive on March 29 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows: arteritis Obliterans
Gangrene of right leg
from thigh downward
(duration) yrs. mos. 33 ds.
CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 3-1-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John F. Coughlin M. D.
4, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Tiler
Date of Burial Mar 31 1930
20. Undertaker F. E. Drake
Address Twin Falls

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76023

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hattie M. Gish

(a) Residence. No. 819 - 2nd Ave N St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Edwin M. Gish

6. DATE OF BIRTH (month, day and year) Dec - 28 - 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55 -	3	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) F Iowa

PARENTS

10. NAME OF FATHER Alex Babcock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind
12. MAIDEN NAME OF MOTHER Jane Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant C. H. Gish
(Address) 819 - 3rd ave N Twin Falls

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1930, to March 28th 1930,
that I last saw h~~er~~ alive on March 29, 1930
and that death occurred, on the date stated above, at 12 - mid night.
The CAUSE OF DEATH* was as follows:
Acute Pancreatetes

(duration) yrs. mos. One ds.
CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) ~~10~~ 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John W. Vaughn M. D.
4-1, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Twin Falls Ida	4-1 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Idaho

should state CAUSE OF DEATH in full, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70024

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louisa A Read

(a) Residence. No. 448 So. Maine Ave. St. 44
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Read

6. DATE OF BIRTH (month, day and year) Nov. 28 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	4		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Frank Tickett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Cecilia Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Frank Read
(Address) 448 So Maine City.

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to Mar 28, 1930
that I last saw her alive on Mar 28, 1930
and that death occurred, on the date stated above, at 12+ A m.
The CAUSE OF DEATH* was as follows:
Cancer of Pancreas
Stomach & Duodenum.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Mar 27/30
Was there an autopsy? No
What test confirmed diagnosis? Surg. & Laboratory
(Signed) John R Morgan, M. D.
Mar 29, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Marion Ida	3/29 1930
20. Undertaker J. J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, THOUSANDS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70025

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Verden Thomick Sorenson

(a) Residence. No. Twin Falls St. or Place

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 16/1901

7. AGE Years 29 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Mechanist

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER N P Sorenson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Thomick

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs V T Sorenson

(Address) Paris Idaho

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to March 24, 1930

that I last saw him alive on March 24, 1930

and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Peritonitis.

(duration) yrs. mos. several ds.

CONTRIBUTORY (Secondary) Rupture of jejunum.

(accidental: motorcycle

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Twin Falls, Id.

Did an operation precede death? yes. Date of Mar. 14, 1930.

Was there an autopsy? no. findings.

What test confirmed diagnosis? clinical & laboratory

(Signed) W. F. Passer M. D.

March 26 1930 (Address) Twin Falls, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ovid Idaho

Date of Burial 19

20. Undertaker F E Drake

Address

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76026

PLACE OF DEATH
County of Twin Falls
City of Twin Falls.

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna D. Ralston

(a) Residence. No. 504 Blue Lakes Blvd St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. C. Ralston

6. DATE OF BIRTH (month, day and year) March 4-1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	0	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10. NAME OF FATHER Archibald Deery
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Sara Kerr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Mrs. W. H. Beercombe
(Address) 504 Blue Lakes Blvd

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on March 18, 1930, to —, 19—
that I last saw her alive on March 15, 1930
and that death occurred, on the date stated above, at 8 am m.
The CAUSE OF DEATH* was as follows:
carcinoma of lower jaw, extending to left side of neck & shoulder
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? clinical only.
(Signed) F. Morrison, M. D.
March 25, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Los Angeles Calif	19
20. Undertaker White Mortuary	Address Twin Falls Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70027

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 101B

2. FULL NAME Edward C Ford
(a) Residence. No. Kimberly St. Dr Dwight 2-30
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 3

7. AGE Years 43 Months 4 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) B. D.

PARENTS
10. NAME OF FATHER Henry Ford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ellen Darrow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penna

14. Informant Mrs E R Ford
(Address) Kimberly

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March, 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to Mar. 22, 1930
that I last saw him alive on March 21 —, 1930.
and that death occurred, on the date stated above, at 2:30 a.m.
The CAUSE OF DEATH* was as follows:

Surgical Pneumonia.
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastric ulcer, involving mesenteric glands & pancreas.
4 years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes. Date of Mar 17-30
Was there an autopsy? No.
What test confirmed diagnosis? Clinically.
(Signed) F. A. Dwight M. D.
March 24, 1930 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal ~~Hawthorne~~ B. D. Date of Burial March 19

20. Undertaker F. E. Drake Address Twin Falls

Cleveland.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70028

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

122

2. FULL NAME Herman E. Voss
(a) Residence. No. 546 2nd Ave East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 25 1862

7. AGE: Years 78, Months 1, Days 27. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: Herman Voss
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Dont know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs George Albert
(Address) 546 2nd Ave. East City

15. Filed April 5th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1927, to Mar 23, 1930
that I last saw him alive on March 2, 1930
and that death occurred, on the date stated above, at [illegible]
The CAUSE OF DEATH* was as follows: Scirrhosis of liver
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Edema with respiratory failure (duration) yrs. mos. 7 & 8 ds.

18. Where was disease contracted if not at place of death? X X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Dr John R Morgan, M. D.
Mar 25 1930 (Address) Central Bldg Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Mar 25 1930

20. Undertaker: F J Grossman
Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76029

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St. Luke's Hospital) 10
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline Elizabeth Hamilton
(a) Residence. No. Addison Ave West St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Harry Hamilton

6. DATE OF BIRTH (month, day and year): Jan. 16 1900

7. AGE: Years: 30 | Months: 2 | Days: 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, of establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: George B. Yount
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.
12. MAIDEN NAME OF MOTHER: Mary Bugbee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Harry Hamilton
(Address) Twin Falls

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1930, to Mar. 21, 1930
that I last saw h[illegible] alive on Mar. 21, 1930
and that death occurred, on the date stated above, at 4:00 A m.
The CAUSE OF DEATH* was as follows:
Encephalitis, meningeal.
accute
(duration) — yrs. 1 mos. — ds.
CONTRIBUTORY
(Secondary)
— — — (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Hospital, Twin Falls.
Did an operation precede death? No. Date of — — —
Was there an autopsy? No. Clinical & Laboratory findings.
What test confirmed diagnosis?
(Signed) M. F. Paar, M. D.
Mar 22, 1930. (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ottumwa Iowa — Date of Burial 19
20. Undertaker: C. J. Isaman — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70030

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48 (3)

2. FULL NAME Mary Meunier
(a) Residence. No. 4 miles S.W. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emery Meunier

6. DATE OF BIRTH (month, day and year): March 30-1882

7. AGE: Years 47 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Calumet Mich

PARENTS
10. NAME OF FATHER: Joseph Martell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Mary Mastha
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Emery Meunier
(Address): Twin Falls. Ida Route #1

15. Filed April 5th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8th, 1930, to March 21, 1930
that I last saw her alive on March 20, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH was as follows: Acute Dilation of heart. Myocarditis
(duration) yrs. mos. 10 days ds.
CONTRIBUTORY (Secondary): Pleurisy in left side
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) John L. Coughlan M. D.
3-24 1930. (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery | Date of Burial: 3-26 1930

20. Undertaker: White Mortuary Inc | Address: Twin Falls. Ida

FROM is very important. See instruction on back of certificate.

1405

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70031

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44

2. FULL NAME James S. McElligott
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula McElligott

6. DATE OF BIRTH (month, day and year): Nov. 11 - 1875

7. AGE: 54 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): and Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Maroa Co. ~~Iowa~~ Pa

PARENTS

10. NAME OF FATHER: John McElligott
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pa
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa. ~~Ireland~~

14. Informant: Mrs. Marie Moore
(Address): Los Angeles, Calif.

15. Filed: April 5th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 25, 1930, to March 20, 1930
that I last saw him alive on March 20, 1930
and that death occurred, on the date stated above, at 7 55 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma Stomach (Lower half)
Secondary - in Liver + Pancreas.
(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary): Toxemia from Obstruction
(duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of March 8/30
Was there an autopsy? No
What test confirmed diagnosis? Operation - X rays
Stomach Analysis
(Signed) Duncan L. Alexander M. D.
3-21, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer, Idaho. Date of Burial: 3-22 1930

20. Undertaker: White Mortuary Inc. Address: Twin Falls, Ida.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70032

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls.

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Stockwell

(a) Residence. No. 553 - 5th Ave E. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sterling Kan

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Lee Logan
(Address) 553 - 5th Ave E.

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13th, 1930, to March 20, 1930
that I last saw him alive on Mar. 19, 1930
and that death occurred, on the date stated above, at 12 noon M.
The CAUSE OF DEATH* was as follows:
acute Dilation of Heart

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Valvular heart dis
case & myocarditis
(duration) 12 yrs. mos. ds.

18. Where was disease contracted if not at place of death? c
Did an operation precede death? No Date of c
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John H Logan M. D.
3-21 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	3-24 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida

TION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76033

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 179 Buhl St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Marie Dehnert

(a) Residence. No. (Usual place of abode) Buhl St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4 1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	1	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Brooks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): —
12. MAIDEN NAME OF MOTHER: [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): [illegible]

14. Informant: R W. Dehnert
(Address) Buhl

15. Filed April 5th, 1930. Elizabeth G. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 20 (Month) (Day) 1930 (Year) 3-15

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to March 20, 1930
that I last saw her alive on Mch 20, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Burns - 75% of body
Started fire in stove with
Kerosene (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Buhl - Ida.
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. H. Scott, M. D.
3-21, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl	Mar 22 1930

20. Undertaker: F C Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

70033

Dr. Chas. R. Scott
Twin Falls, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Myrtle Marie Denhert who died at Twin Falls, Idaho on March 20, 1930
Cause of death given as "burns 75% of body."

Information DESIRED in order to complete certificate:

WAS A BURNING BUILDING INVOLVED. IF SO, PLEASE STATE, AS THESE ARE CLASSIFIED SEPARATELY.

PLEASE ANSWER BELOW:

No - She started fire on Stove with Kerosene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70034

Registration District No. ____
Primary Registration District No. ____
Local Registrar's No. ____

PLACE OF DEATH
County of Twin Falls
City of Twin Falls (No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J M Black 90

(a) Residence. No. ____ St. ____
(Usual place of abode)
Length of residence in city or town where death occurred. ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 10 / 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	11	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Andrew Black
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Elizabeth Lowery
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs Zura Black
(Address) Twin Falls

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____m.

The CAUSE OF DEATH* was as follows:
Myo. Cardiac Insufficency
Acute
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Died Unattended
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) F L Drake (Coroner) M. D.
____, 19____ (Address) ____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 20 1930

20. Undertaker F L Drake — Address Twin Falls

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70036

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

91 B

2. FULL NAME Alice Riley

(a) Residence. No. 302 - 5th Ave N. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 24 - 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Knox Co - Ill.

PARENTS

10. NAME OF FATHER William L. Riley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indianna
12. MAIDEN NAME OF MOTHER Louisa Wilcox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky

14. Informant Miss Etta Riley
(Address) 302 - 5th Ave N.

15. Filed April 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH - 3 (Month) - 16 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1910, to March 16, 1930 that I last saw h.. alive on March 16th, 1930 and that death occurred, on the date stated above, at 9 p. m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis General.

(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostasy —
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Duncan K Shumaker, M. D.
March 14, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls - Idaho	3 - 18 1930

20. Undertaker	Address
White Mortuary Inc	Twin Falls. Ida.

TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70037

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

117

2. FULL NAME Maude Leinen

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Dr Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29 / 1889

7. AGE: Years 40, Months 7, Days 16. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Wife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER H. J. Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Mary Crouer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XXX

14. Informant J. O. Leinen
(Address) Filer

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11th, 1930, to March 16, 1930
that I last saw her alive on March 15, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Appendicitis chronic with acute exacerbation
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Embolism Lung.
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Filer Ida.
Did an operation precede death? Yes Date of March 14th 30
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Duncan L. Alexander, M. D.
March 16, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetery — Date of Burial: Mar 17 1930

20. Undertaker: F. E. Drake — Address: Twin Falls

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70038

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

146

2. FULL NAME Helen Maxine Cunningham
(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 20 / 1911

7. AGE: Years 18 Months 5 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Wife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS
10. NAME OF FATHER: E C Gardner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebr
12. MAIDEN NAME OF MOTHER: Nellie Hampson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska

14. Informant: E C Gardner
(Address) Jerome Route III

15. Filed April 5th, 1930. Elizabeth J Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Mch 9, 1930
that I last saw her alive on Mch 8, 1930
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
toxemia of pregnancy
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary): appendicitis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Feb 12
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. R. Scott, M. D.
Mch 10, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Date of Burial: Mar 11 1930

20. Undertaker: F E Drake Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70039

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

41

2. FULL NAME Helen Hodges

(a) Residence. No. Jerome St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 27

7. AGE Years 14 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER B M Hodges
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Iva Carson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant B M Hodges
(Address) Jerome

15. Filed April 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2nd, 1930, to March 5, 1930
that I last saw her alive on March 5, 1930
and that death occurred, on the date stated above, at 3:20 a m.
The CAUSE OF DEATH* was as follows:
Streptococci infection Pharynx
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) ① Appendicitis supp. acute ② Peritonitis suppuration acute, ③ Pneumonia Lobar Right acute
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Jerome Co Idaho
Did an operation precede death? YES Date of March 2/30
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Operation
(Signed) Duncan L. Alexander, M. D.
3/6/30, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls | Date of Burial March 1930

20. Undertaker T. L. Drake | Address Twin Falls

RECEIVED APR 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70046

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. /
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Horace Eugene Sheldon
(a) Residence. No. 128 - 10th Ave N. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Clara Sheldon

6. DATE OF BIRTH (month, day and year) March 29-1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	11	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Businessman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Burlington (State or country) Wis

PARENTS
10. NAME OF FATHER Orson Sheldon
11. BIRTHPLACE OF FATHER (city or town) Rupert (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Rosa Ann Lippitt
13. BIRTHPLACE OF MOTHER (city or town) New York (State or Country)

14. Informant Mrs. M. E. Jennison
(Address) 128 - 10th Ave N.

15. Filed April 5th, 1930 Elizabeth J Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 24th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1928, to Mch. 3, 1930
that I last saw h~~im~~ alive on March 3, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ——
Did an operation precede death? No Date of ——
Was there an autopsy? No
What test confirmed diagnosis? Ordinary
(Signed) A W Nelson, M. D.
March 25, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	3-6 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70041

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Euphrates Metts
(a) Residence. No. Hazelton Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. Dr Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 21 1915

7. AGE: Years 15 Months — Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: C C Metts
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Texas
12. MAIDEN NAME OF MOTHER: Lona Holland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Okla

14. Informant: C C Metts
(Address) Hazelton Ida

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 24 9-10 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21, 1930, to Mar 24, 1930
that I last saw him alive on Mar 24, 1930
and that death occurred, on the date stated above, at 9-10 p.m.
The CAUSE OF DEATH* was as follows: (5 days)
Cardiac Decompensation following lobar pneumonia (72 days)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E L Berry, M. D.
Mar 27, 1930 (Address) Bahr

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida
Date of Burial: Mar 30 1930

20. Undertaker: F E Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70042

PLACE OF DEATH
County of Washington
City of Weiser Idaho
Registration District No.
Primary Registration District No.
(No. Moorehead Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 164

2. FULL NAME Mrs. Caroline Seagraves
(a) Residence. No. Midvale Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Seagraves

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79 1851	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Phillips Hemical ash. Co. North Carolina

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER John Black
11. BIRTHPLACE OF FATHER (city or town) (State or Country) — North Carolina
12. MAIDEN NAME OF MOTHER Rhea
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Phillips Hemical
(Address) Midvale Idaho

15. Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1st, 1930, to March 15, 1930
that I last saw her alive on March 15th, 1930
and that death occurred, on the date stated above, at 2:10 P m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. L. Lamont, M. D.
3/19-30, 19..... (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Midvale Idaho	Mch 17-1930

20. Undertaker L. Rodgers — Address Midvale Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED MAR 21 1930

DO NOT WRITE IN THIS SPACE
State File No. 70044

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 6
Primary Registration District No. 1010
Local Registrar's No. 15

(No.) 117
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marion Phelps.

(a) Residence. No. New Meadows Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Mother dead no record of birth

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Working With Sheep
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Don't Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Parlee Phelps
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant C. B. Carr
(Address) New Meadows Ida

15. Filed March 5th, 1930 W. S. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Mar 4, 1930
that I last saw him alive on Mar 4, 1930
and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:
Rupture of spleen with Peritonitis
(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Feb 29
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) F. A. Schmidt M. D.
Mar 5th, 1930. (Address) New Meadows Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	3-6-1930

20. Undertaker	Address
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70045

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
Local Registrar's No. 14
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME James Garland White
(a) Residence No. Weiser Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie White

6. DATE OF BIRTH (month, day and year) Dec 4 - 1876

7. AGE 54 Years | Months 1 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER E. R. White
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Theobe Frazier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Jennie White
(Address) Weiser Ida R. 4

15. Filed March 3, 1930 Jr R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to ....., 19..
that I last saw him alive on Mar 1 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows: empyema - discharging through lung
about
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Sant Rum
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? discharge of pus
(Signed) G M Waterhouse, M. D.
Mch 2, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview Cemetery, Ore
Date of Burial: 3 - 3 - 1930

20. Undertaker: L. C. Northam
Address: Weiser Ida

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70047

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 1110
Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Martha Jane Ronne

(a) Residence. No. 252 E Court St
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of F. M. Ronne

6. DATE OF BIRTH (month, day and year) Feb 1 - 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clearwater W. Va

PARENTS

10. NAME OF FATHER Richard Lewis ~~Don't Know~~

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Chas Ronne
(Address) Weiser Ida

15. Filed Apl 20th, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1925, to Feb 17, 1930
that I last saw her alive on Feb 17, 1930
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cardiac debility - 4 days.
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Goitre
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. W. Marshall, M. D.
Feb 18, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Weeping Water Neb.	
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

5

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70048

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Mary Rosanna Ricks

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Whr
5. Single, Married, Widowed, or Divorced (write the word) ~~Married~~ Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Ricks

6. DATE OF BIRTH (month, day and year) Aug. 8. 1889

7. AGE Years 42 Months 6 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Logo
(State or country) Idaho

PARENTS

10. NAME OF FATHER John Gibbs
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Nancy Loveland
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant Adele Dille
(Address) Weiser Ida

15. Filed Feb 15th, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 1, 1928, to Febry 14, 1930
that I last saw her alive on Febry 14, 1930
and that death occurred, on the date stated above, at 9:30 m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (duration) 0 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) C. C. Conant, M. D.
2-14-30, 19.... (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 2-16- 1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70049

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 71
Primary Registration District No. 1010
Local Registrar's No. 10
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Iva H Cooper

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 19—

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
[illegible]	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Will Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebr.
12. MAIDEN NAME OF MOTHER Iva Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Iva Davis
(Address) Weiser Ida

15. Filed Feb 12th, 1930 H. K. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feby 11th, 1930
that I last saw her alive on Feby 11th, 1930
and that death occurred, on the date stated above, at 10:09 m.

The CAUSE OF DEATH* was as follows:
Typhoid fever
(duration) yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was *disease contracted* if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) C. C. Lamont, M. D.
2/19/30, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	2-13-1930
20. Undertaker F. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76050

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 9

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M Sheridan

(a) Residence. No. 472 E Com St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Laura L Sheridan

6. DATE OF BIRTH (month, day and year) Apr. 17 - 1844

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	9	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John B Sheridan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant John Sheridan
(Address) Weiser Ida

15. Filed Feb 12 1930 W L Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1930, to Feb 9 1930, that I last saw h alive on Feb 9 1930 and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Toxemia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Cystitis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) W. L. Hamilton, M. D.
Feb 10 1931 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	2-12 1930
20. Undertaker L C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70051

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Charles Briggs

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 76 — Months: — Days: — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Would not Tell

PARENTS

10. NAME OF FATHER Would not Tell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Would not tell
12. MAIDEN NAME OF MOTHER Would not tell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Would not tell

14. Informant Providence Hospital
(Address) Weiser Ida

15. Filed Feb 9th, 1930 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 '28, 19 to Feby 8th, 19 30
that I last saw h— alive on Feby 8th, 19 30
and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis.
(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. H. Lamont M. D.
2/8/30, 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	2-11-1930
20. Undertaker L. L. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 76052

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 56
Primary Registration District No. 2112
Local Registrar's No. 7
(No. About 3 Miles North of Weiser.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

189C

2. **FULL NAME** Arthur Elroy Fackler

(a) Residence. No. McCall, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sylvia Fackler.

6. DATE OF BIRTH (month, day and year) October 7th 1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	3	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Iowa.
(State or country)

PARENTS

10. NAME OF FATHER Henry H. Fackler.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wis.

12. MAIDEN NAME OF MOTHER Isabel Thomson.

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Canada.

14. Informant Mrs. Sylvia Fackler.
(Address) McCall, Idaho.

15. Filed Jan 29th 1930 M K Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 27th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on about , 19
and that death occurred, on the date stated above, at 9:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accidental - Caused by auto truck loaded coal & lumber going off highway and turning over on him. Thighs supposed to have gone out
(duration) yrs. mos. ds.
CONTRIBUTORY On North & South Highway
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) N. E. Northam Coroner ~~M. D.~~
Jan 28 – 1930 (Address) Weiser, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 19

20. Undertaker: P. Northam. Address: Weiser, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70053

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 76
Primary Registration District No. 2112
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert Thomas Meacham 49

(a) Residence. No. Weiser, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ann Ella Meacham

6. DATE OF BIRTH (month, day and year) May 6, 1858

7. AGE Years 71 Months 8 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Orchardist
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clay, Iowa

PARENTS
10. NAME OF FATHER Alan Meacham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Woodmanse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ann Ella Meacham
(Address) Weiser, Idaho

15. Filed Jan 27th, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1930, to Jan 25, 1930
that I last saw him alive on Jan 24, 1930
and that death occurred, on the date stated above, at 11 30 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris.
..... (duration) ..... yrs. ..... mos. 30 ds.
CONTRIBUTORY (Secondary) Arteria Sclerosis.
..... (duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Physical Exam.
(Signed) Ernesto Finney, M. D.
Jan 29, 1930 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial Jan 28 - 1930

20. Undertaker L. C. Northam — Address Weiser Ida

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70054

Registration District No. 56
Primary Registration District No. 1010
Local Registrar's No. 5

PLACE OF DEATH

County of Washington
City of Weiser

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Freeman T. Page

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wh	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Isabell Page

6. DATE OF BIRTH (month, day and year) Aug 1st 1845

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	5	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Heman Page
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Carl Page
(Address) Weiser Idaho

15. Filed Jan 27th, 1930 W R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 25, 1930
that I last saw h— alive on Jan 25, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Senile Dementia
.....
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) C. E. Lyman M. D.
1/25/30, 19— (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-28-1930
20. Undertaker W. B. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70055

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 96
Primary Registration District No. 2112
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Malissa Ann Shaw

(a) Residence. No. .... St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James Shaw

6. DATE OF BIRTH (month, day and year) Nov. 26 - 1851

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
78	1	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Robert Baton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Mrs Thos Waldrop
(Address) Weiser Idg

15. Filed Jan 26, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1930, to Jan 25, 1930
that I last saw her alive on Jan 24, 1930
and that death occurred, on the date stated above, at .... m.
The CAUSE OF DEATH* was as follows:

Cardiac dilatation + regurgitation
(duration) .... yrs. 2 mos. .... ds.

CONTRIBUTORY (Secondary) ....
(duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? ....
(Signed) W D Marshall, M. D.
Jan. 26, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-29-1930
20. Undertaker L. L. Northam	Address Weiser, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70056

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 3

49

2. FULL NAME Frank Albert Bain

(a) Residence. No. Eaton St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Whp
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lura Bain

6. DATE OF BIRTH (month, day and year) Mar 3 1880

7. AGE Years 49 Months 10 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER B. F. Bain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Amanda Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Lura Bain
(Address) Weiser, Idaho

15. Filed Jan 10th, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to Jan 6, 1930
that I last saw him alive on Jan 6, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of lung.

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov. 16
Was there an autopsy? no
What test confirmed diagnosis? operation for drainage
(Signed) W. Marshall, M. D.
Jan 8, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 1-11-1930

20. Undertaker L. C. Northam — Address Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70057

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 66
Primary Registration District No. 1612
Local Registrar's No. 2
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Beebe Addington Kimball

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gilbert F Kimball

6. DATE OF BIRTH (month, day and year) Mar 12-1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Moses Addington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Gilbert F Kimball
(Address) Weiser Idaho

15. Filed Jan 4th, 1930 M. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1. 1928, to Dec 31. 1929
that I last saw her alive on Dec 31 1929
and that death occurred, on the date stated above, at 7. P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W M Marshall M. D.
Jan 5 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-4-1930
20. Undertaker L. C. Northam	Address Weiser. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70058

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

49

2. FULL NAME Laura M Sheridan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John M Sheridan

6. DATE OF BIRTH (month, day and year) May [illegible]

7. AGE Years 78 Months 7 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER S B. Cotterell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emily Cotterell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Alvilda F. McLeod
(Address) 809 S. G. St Tacoma Wash

15. Filed Jan 2nd, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to Dec 30, 1929
that I last saw her alive on Dec 30, 1929
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Splean
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W H Marshall, M. D.
Jan 5, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 1-5-1930

20. Undertaker L. C. Northans — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 5 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Cambridge
(No. ....., ... St.)

Registration District No. .....
Primary Registration District No. .....

File No. 76059
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Maud

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1868 (Year)

7. AGE: 61 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Lester

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Carroll

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R T. Richards
(Address) .....

15. Filed 4-3-30 191.... R T Richards Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1-30 191..., to 3-28-30 191..., that I last saw h-- alive on 3-28-30 191..., and that death occured on the date stated above, at 2.10 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.
.....
.....
(Duration) 3 Yrs. ... mos. ... ds.
Contributory (Secondary) Hypertension - Uremia
(Duration) 3 mos. ds.
(Signed) W. H. Simon M. D.
19.... (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida. DATE OF BURIAL: 4-1 1930

20. UNDERTAKER: J C Anderson ADDRESS: Cambridge Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 5 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70060

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

2. FULL NAME Mary Matilda Hiltibiddle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Write the word.)

6. DATE OF BIRTH. March (Month) 25 (Day) 1844 (Year)

7. AGE 85 Yrs. 10 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Anda Ellithorpe

11. BIRTHPLACE OF FATHER (State or Country) Mass

12. MAIDEN NAME OF MOTHER Matilda Stewart

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Hiltibiddle

(Address) .....

15. Filed 4-3-30 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1930, to Feb. 11 1930, that I last saw her alive on Feb. 11 1930, and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Bronchial Asthma

.....(Duration .....yrs. .....mos. .....ds.

(Signed) G. R. Hunt D.C. ~~M. D.~~

.....19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida

DATE OF BURIAL Feb. 12 1930

20. UNDERTAKER J. A. Hudelson

ADDRESS Cambridge

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 5 1930

70061

DO NOT WRITE IN THIS SPACE

State File No. 70061

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

PLACE OF DEATH

County of Gem

City of Emmett

(No. 170)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver C. Baisch

(a) Residence. No. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sue Ellen Baisch

6. DATE OF BIRTH (month, day and year) Dec 31 - 1902

7. AGE	Years	Months	Days	If LESS than 1 day,
	27	3	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Palisade
(State or country) Colorado

PARENTS

10. NAME OF FATHER Fred Baisch

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Anna K. Hottes

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Illinois

14. Informant Fred C. Baisch
(Address) Emmett Idaho

15. Filed 4/28, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24 -, 1930, to Apr 24, 1930
that I last saw him alive on Apr 24, 1930
and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Gunshot Suicide
Probable mental derangement
due to Epilepsy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Can't tell

Did an operation precede death? Yes Date of Spring of 1928
Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. L. Reynolds, M. D.
4/28, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, Cremation, or ~~Removal~~	Date of Burial
Spokane, Wash	May 1 1930
20. Undertaker O. Buckmun	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

70062

DO NOT WRITE IN THIS SPACE

State File No. 70062

PLACE OF DEATH

County of Twin Falls

City of Burley Ida. Registration District No. 39

Primary Registration District No. 2087 Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lela Virginia Leckie 151

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J. C. Leckie

6. DATE OF BIRTH (month, day and year) June 27-1873

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Algiers Louisiana

PARENTS

10. NAME OF FATHER Benton Richardson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Louisiana

12. MAIDEN NAME OF MOTHER Delphy Nugent

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Louisiana

14. Informant (Address) R. C. Leckie Burley Ida.

15. Filed Apr. 18, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4-10 1930, to 4-18 1930,
that I last saw h[er] alive on 4-18 1930
and that death occurred, on the date stated above, at 7 30 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Diabetic Gangrene

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab.

(Signed) Fred Jennings, M. D.
4-18, 1930 (Address) Burley Ida

19. Place of ~~Burial, Cremation,~~ or Removal Oklahoma City, Okla. Date of Burial 19

20. Undertaker L. Johnson Address Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

70063

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70063

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 134
(No. 1428 East State Streets.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

493

2. FULL NAME John Bullock

(a) Residence. No. 1428 East State St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 29 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margorie Bullock

6. DATE OF BIRTH (month, day and year) January 25th 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER C. E. Bullock.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Ella C. Topping.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wis.

14. Informant C. E. Bullock.
(Address) Boise, Idaho.

15. Filed 5-13, 1930 W. W. Rhodes Registrar.
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 11, 1930, that I last saw him alive on May 11, 1930, and that death occurred, on the date stated above, at 3 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis
unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coliemia
unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) S. E. Ray, M. D.
5/12/30, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/13/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED MAY 12 1930

70664

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70064

PLACE OF DEATH
County of CUSTER
City of MACKAY (WHITE KNOB) Registration District No. 16
Primary Registration District No. 2153 Local Registrar's No. 132
(No. 196)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME FRANK WORNEK

(a) Residence. No. ..... St. .....
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of SYLVIA WORNEK

6. DATE OF BIRTH (month, day and year) 22 October 1902

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work QUARTZ MINER
(b) General nature of industry, business, or establishment in which employed (or employer) COPPER MINING
(c) Name of employer MACKAY METALS

9. BIRTHPLACE (city or town) MACKAY (State or country) IDAHO

PARENTS

10. NAME OF FATHER JOHN M WORNEK
11. BIRTHPLACE OF FATHER (city or town) (State or Country) OHIO
12. MAIDEN NAME OF MOTHER ELLURA BELLE DRINNER
13. BIRTHPLACE OF MOTHER (city or town) (State or County) IOWA

14. Informant (Address) OSCAR WORNEK MACKAY IDAHO

15. Filed 5/10, 30 Rose Nauroe Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from NO MEDICAL ATTENTION, 19..., to ..., 19...
that I last saw h..... alive on ..., 19...
and that death occurred, on the date stated above, at "2 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

ACCIDENTAL GREAT CRUSHING OF CHEST
AND VITAL ORGANS THEREIN BY BEING CAUGHT
UNDER CAVING ROCK WEIGHING SEVERAL TONS (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) IN COPPER MINE: INSTANT DEATH. (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? YES
What test confirmed diagnosis? J. P. AUTOPSY
(Signed) J. P. Richards, M. D.
7 May, 1930 (Address) Mackay, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay Idaho	May 9 1930
20. Undertaker Asher R. Garner	Address Mackay Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

70065

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70065

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 76
Primary Registration District No. 2153 Local Registrar's No. 130
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

186

2. FULL NAME Herbert Fyfe Hilts
(a) Residence. No. Mackay, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 25 yrs. — mos. — ds. — How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE mt
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X
6. DATE OF BIRTH (month, day and year) Sept. 23, 1887
7. AGE Years 42 Months 6 Days 12 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner & farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Mining
(c) Name of employer Mackay Metal Co.
9. BIRTHPLACE (city or town) (State or country) Stevensville, Mont.

PARENTS
10. NAME OF FATHER Ezra J. Hilts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario, Canada
12. MAIDEN NAME OF MOTHER Eleanor Hoskins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Fairfield, Iowa

14. Informant (Address) Elva Douglas Hilts 1009 N. 12th Boise, Idaho
15. Filed 5/10, 1930. Rose Nowacki Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 5 (Day) 1930, 19 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/4/30, 19, to 4/5/30, 19
that I last saw him alive on 4/5/30, 19
and that death occurred, on the date stated above, at 9:30A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Struck on head by descending mine cage.
CEREBRAL HEMORRHAGE * SHOCK

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) FRACTURE SKULL AT BASE.
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 4/4/30
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) , M. D.
4/5/30, 19 (Address) Mackay, Idaho

19. Place of Burial, Cremation, or Removal Mackay, Idaho
Date of Burial Apr. 6 1930
20. Undertaker Theo. R. Garnier
Address Mackay, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

70066

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70066

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 128
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

128

2. FULL NAME Francis Bert Rigby.

(a) Residence. No. Salt Lake City, Utah. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 24th 1905

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
25	0	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auditor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah.

PARENTS

10. NAME OF FATHER Charles S. Rigby.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Catherine Lemon.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Paradise, Utah.

14. Informant (Address) Ralph G. Rigby. Salt Lake City, Utah.

15. Filed 5-8, 1930 W. H. Rhodes Registrar. R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---- 19---, to ---- 19---, ~~that I last saw him alive on~~ ---- 19---, and ~~that~~ death occurred, on the date stated above, at 1:15 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
accidently killed in
Auto Accident.
Inquest Held.
Coroner's Jury Verdict (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) on file
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No. Date of ----
Was there an autopsy? No. ----
What test confirmed diagnosis? ----

(Signed) Wm McBratney - Coroner M. D.
5/5/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Salt Lake City, Utah. Date of Burial: 5/5/30 Shipped 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

70067

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70067

Registration District No. 2
Primary Registration District No. 6004
Local Registrar's No. 130

PLACE OF DEATH
County of Ada
City of Boise
(No. 115 W. Jefferson)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Lena E. Carpenter

(a) Residence. No. ~~415 West Jefferson~~ St. Garden Valley Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nazaire A. Carpenter

6. DATE OF BIRTH (month, day and year) Oct 18, 1873

7. AGE Years	Months	Days	If LESS than 1 day,
56	6	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Black Station, Ada Co.

PARENTS
10. NAME OF FATHER Pierre Mercier
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Ernest B Carpenter
(Address) Garden Valley Idaho

15. Filed 5-10, 1930 W. L. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to May 8, 1930
that I last saw h~~e~~r alive on May 8, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Leo Callen M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	5/10 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70068

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 5

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert B. Lloyd

(a) Residence. No. ..... St. 44
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A Lloyd

6. DATE OF BIRTH (month, day and year) May 2. 1852

7. AGE Years 77 Months 10 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pitsburg Penn

PARENTS
10. NAME OF FATHER Wm Lloyd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant Sarah Alice Lloyd
(Address) Meridian Idaho

15. Filed 3/6, 1930 N F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ examined deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) N F Neal, M. D.
March 5, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill
Date of Burial Mar 7 1930

20. Undertaker W S Mateer Meridian
Address

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70069

PLACE OF DEATH

County of Ada

City of Meridian

Registration District No. 11 Dr Bridges

Primary Registration District No. 2003 Local Registrar's No. 6

(No. 8 St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1013

2. FULL NAME Charles William McKinley

(a) Residence. No. (Usual place of abode) 8 St. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20 - 1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	14	6	28	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida

PARENTS

10. NAME OF FATHER J. C. McKinley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stronghurst Ill.

12. MAIDEN NAME OF MOTHER Lorene Hackett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Waterloo Ia

14. Informant C. M. McKinley
(Address) Twin Falls Ida

15. Filed Apr 19, 1930 H. F. Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-13-, 1930, to 4-17, 1930
that I last saw her alive on 4-17, 1930
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Septicemia Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. F. Neal, M. D.

4-18, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	Apr 20 1930

20. Undertaker W. S. Waters Address Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20070

PLACE OF DEATH
County of Ada
City of Meridian St

Registration District No. 11
Primary Registration District No. 2003
(No. 119)
Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sola Tollett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Floyd Tollett

6. DATE OF BIRTH (month, day and year) June 9 1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	10	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER W P Pendleton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Elizabeth Arnhart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant W P Bradleton
(Address) Nampa Ida

15. Filed 4-22-, 1930 N F Reed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-21-, 1930, to 4-21-30, 19..
that I last saw h— alive on 4-20-30, 19..
and that death occurred, on the date stated above, at 11 4. m.
The CAUSE OF DEATH* was as follows:

Ulcerative Colitis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Proctoscopic & Barium Enema
(Signed) Geo. E. Clark M. D.
4-21-, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Idaho	23- 1930
20. Undertaker	Address
W B Mathes	Meridian Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70071

PLACE OF DEATH

County of Ada

City of Meridian

Registration District No.

Primary Registration District No.

Local Registrar's No. 8

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Donald Maynard Watkins

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6th 1930

7. AGE Years — Months — Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Meridian
(State or country) Ida

PARENTS

10. NAME OF FATHER Bert R. Watkins

11. BIRTHPLACE OF FATHER (city or town) Austin
(State or Country) Minn

12. MAIDEN NAME OF MOTHER Ruth Morey

13. BIRTHPLACE OF MOTHER (city or town) Hanesboro
(State or Country) Minn

14. Informant Bert R Watkins
(Address) Meridian Ida

15. Filed 4/26, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26-, 1930, to 4-26, 1930
that I last saw him alive on 4-26, 1930
and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:
Acute Indigestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Premature Break

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H F Neal, M. D.
4-27, 1930 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Meridian Ida — Date of Burial 4-27 1930

20. Undertaker B W Robison — Address Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70072

PLACE OF DEATH

County of Ada.
City of Boise

CERTIFICATE OF DEATH

Registration District No. 9-10
Primary Registration District No. 9-0 Local Registrar's No. 1
(No. 1-1/2 Mile South of Star, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1/2

2. FULL NAME Rollo C. Fry
(a) Residence. No. Harper, Oregon. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Fry.

6. DATE OF BIRTH (month, day and year): February 9th 1892

7. AGE: Years 38, Months 2, Days 12. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Cornucopia, Oregon.

PARENTS

10. NAME OF FATHER: George G. Fry.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Laura A. Walk.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ind.

14. Informant (Address): Mrs. Emma Fry. Harper, Oregon.

15. Filed Apr 24, 1930 [signature] Registrar. Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20th or 21st 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ Death occured on date stated above. ~~that I last saw him alive on~~ ~~and that death occurred on the date stated above~~ at ___ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental Drowning. Body found in Canal about 6.30 A.M. Apr. 21-1930.
Accidently drove Automobile into Canal.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ___
Was there an autopsy? No.
What test confirmed diagnosis? ___
(Signed) W McBratney Coroner, M. D.
4/22/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Star Cemetery. Date of Burial: 4/24/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76073

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No.
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Lillian Donnelley.

(a) Residence. No. 4 Hurtt Apartments. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William. J. Donnelley.

6. DATE OF BIRTH (month, day and year) Oct. 13.1882.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37.	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER John Garnett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky.
12. MAIDEN NAME OF MOTHER Mary Riley.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) William. J. Donnelley. # 4. Hurtt Apt. Boise, Idaho.

15. Filed 4-30 1930 W. S. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 19th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 7, 1929, to april 18th, 1930
that I last saw her alive on april 18th, 1930
and that death occurred, on the date stated above, at 3 30a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer originating in the Uterus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to abdomen

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes No Date of aug 7/29
Was there an autopsy?
What test confirmed diagnosis? Biopsy

(Signed) J. D. Springer, M. D.
April 19th 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Madison, Missouri.	April. 23.30
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70074

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 111

(No. St. Alphonsus Hospital ✓

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Elizabeth Van Dorn

(a) Residence. No. 112 Straughn Ave ~~St.~~ 101a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charley Van Dorn

6. DATE OF BIRTH (month, day and year) October 13, 1855

7. AGE Years 74 Months 6 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10. NAME OF FATHER James Mallory

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.

12. MAIDEN NAME OF MOTHER Elizabeth ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Am.

14. Informant Marguerite Van Dorn
(Address) Boise Idaho

15. Filed 4-21, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 16, 1930

that I last saw her alive on April 16, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo Collister M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 4/21 1930

20. Undertaker Schreiber & McCann — Address Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70075

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 112
(No.) ✓
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie May Monroe 46
(a) Residence No. 1222 Idaho St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb-19-1861
7. AGE Years 69 Months 2 Days 0 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Colorado
PARENTS
10. NAME OF FATHER Joel Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Mary Powers
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wisconsin
14. Informant (Address) Mrs Mary Bauer 1222 Idaho St Boise Idaho
15. Filed 4-21 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1929 to 4/20 1930
that I last saw her alive on 4/18 1930
and that death occurred, on the date stated above, at m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus
Metastasis to Intestines & Bladder
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) 7 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3/1/1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A Pittenger M. D.
4/21 1930 (Address) Boise Idaho
19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial April 22 1930
20. Undertaker Summers & Krebs Address Boise Idaho

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 20076

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 112
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Homer I. Clark

(a) Residence. No. Kuna, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 24th 1863

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	3	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Albia, Iowa.
(State or country)

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) "
(State or County)

14. Informant Pearl Allen.
(Address) Boise, Idaho.

15. Filed 4-21, 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th, 1930 to April 20th, 1930
that I last saw him alive on April 19th, 1930
and that death occurred, on the date stated above, at 12:15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Bauch M. D.
4/21/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery,	4/22/30 19
20. Undertaker: Wm. McBratney.	Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70077

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 114

1018

2. FULL NAME Mrs. Agnes Paquin

(a) Residence. No. 915 Washington St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George H. Paquin

6. DATE OF BIRTH (month, day and year) Oct. 31st 1872

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	57	5	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER James Daughterty

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Annie Kelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Geo H Paquin
(Address)

15. Filed 4-21 1930 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 19, 1930
that I last saw her alive on April 19th, 1930.
and that death occurred, on the date stated above, at 5:45 A m.
The CAUSE OF DEATH* was as follows:

Pneumonia.

(dufation) yrs. mos. ds.

CONTRIBUTORY (Secondary) chronic myocarditis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) J Springer, M. D.
April 21, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	4/22 1930

20. Undertaker	Address
Schmitz & McCann	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70078

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 115
(No. St. Alphonsus Hospital.) 14
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rube M. Squier

(a) Residence. No. Grand Junction, Colo. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Squier.

6. DATE OF BIRTH (month, day and year) April 30th 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	11	20	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant P. R. Howerton.
(Address) Boise, Idaho.

15. Filed 4-22, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-15, 1930 to 4-20, 1930
that I last saw h. alive on 4-19, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Rocky Mountain
spotted fever.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carditis

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Blacks Creek
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. P. Draper, M. D.
4/21/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Grand Junction, Colo — Date of Burial: Shipped 4/22/30 19
20. Undertaker: Wm. McBratney. — Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20079

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 116

2. FULL NAME Edward J. Cooley

(a) Residence. No. 510 Washington St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Cooley

6. DATE OF BIRTH (month, day and year) Nov. 1 - 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	5	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Transfer Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Edward J. Cooley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Anna Ashlyn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Effie C. Kellogg
(Address) Nampa Idaho

15. Filed 4-22, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/22, 1930, to 4/21, 1930
that I last saw him alive on 4/21, 1930
and that death occurred, on the date stated above, at 10:15 m.
The CAUSE OF DEATH* was as follows: Myocarditis

(duration) Many yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertonic Neurosis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Roger Neill M. D.
4/22, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4/23 1930
20. Undertaker	Address
Schneider & McCann	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70080

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 7
(No. 1423 Grove Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence W. Olson.
(a) Residence. No. 402 Bannock Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Olson.

6. DATE OF BIRTH (month, day and year) February 16th 1871

7. AGE Years 69 Months 2 Days 7 If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Property Owner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS
10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) L. G. Olson. Boise, Idaho.

15. Filed 4-25, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23rd 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19 to 19~~ ~~that I last saw him alive on 19~~ ~~and that~~ death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead. Probably acute heart attack. Had been having pains in region of Heart for past year (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Natural Cause (duration) No Inquest. yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) W McBratney Coroner, M. D.
4/25/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 4/25/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70081

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 115
(No. 1008 North 9th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

122

2. FULL NAME James Stuart Roberts.

(a) Residence. No. 1008 North 9th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 0 yrs. 10 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mabel Roberts.

6. DATE OF BIRTH (month, day and year) November 29th 1869

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	4	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) U.S.R.Service.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California.

PARENTS

10. NAME OF FATHER George M. Roberts.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Rebecca Clevenger.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant Mrs. Mabel Roberts.
(Address) Boise, Idaho.

15. Filed 4-28, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Jan. 29, 1930 to Apr. 26, 1930 that I last saw h~~im~~ alive on Apr. 24, 1930 and that death occurred, on the date stated above, at 6 A.M m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) H. E. Dedman, M. D.
4/26/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetary.	4/27/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70082

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 119
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME George Jamieson.
(a) Residence. No. 706½ Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE Black (Negro)
5. Single, Married, Widowed, or Divorced (write the word.) Widower.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------
6. DATE OF BIRTH (month, day and year)
7. AGE Years 85 Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Troy, New York.

PARENTS
10. NAME OF FATHER George Jamieson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rochester, N. Y.
12. MAIDEN NAME OF MOTHER Nancy Juliet.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y.

14. Informant (Address) Arthur Jamieson. Ellensburg, Wash.
15. Filed 4-28, 1930 W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 25th 1930, 19 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19, to , 19~~ ~~that I last saw h. alive on , 19~~ ~~and that~~ death occurred, on the date stated above, at 7.45 P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility
Had been in poor health for several months.
Natural Cause, (duration) Old Age yrs. mos. ds.
CONTRIBUTORY (Secondary) No. Inquest (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —
(Signed) W. McBratney Coroner, ~~M.~~ D.
4/26/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 4/28/30 19
20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70083

PLACE OF DEATH
County of Ada
City of Boise, Ida

Registration District No. 2
Primary Registration District No. 1004
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 120

2. FULL NAME John H. Mays
(a) Residence No. 1607 No. 7th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Mays

6. DATE OF BIRTH (month, day and year) May 27 1848

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	10	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morristown, Tenn.

PARENTS

10. NAME OF FATHER Green B. Mays
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Morristown Tenn.
12. MAIDEN NAME OF MOTHER Elizabeth Ivey.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Madisonville, Tenn

14. Informant Thomas J. Mays
(Address) 1607 - No. 7th St.

15. Filed 4-28, 1930 W. M. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1924 to Apr. 25, 1930 that I last saw him alive on Apr. 15, 1930 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:
Myocarditis - (Sudden heart failure)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical Findings

(Signed) H. E. Wegman, M. D.
Apr. 26, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	4/28 1930

20. Undertaker	Address
Schreiber & McCann	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70084

Local Registrar's No. 131

2. FULL NAME Eugene D. Hamilton

(a) Residence. No. 1312 No 7 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Hamilton

6. DATE OF BIRTH (month, day and year) August 6-1867

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	8	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer "The Mode"

9. BIRTHPLACE (city or town) (State or country) Sandgate Vermont

PARENTS

10. NAME OF FATHER Ezra Hamilton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Sarah Prindle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Emma M. Hamilton

(Address) 1312 No 7

15. Filed 4-28, 1930 W. N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to April 24, 1930 that I last saw him alive on Apr. 24 1930 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows: Malignant Fever

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological Tests

(Signed) H. E. Bedaman M. D.

Apr. 26, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	4/28 1930
20. Undertaker	**Address**
Schreiber & McCann	Boise, Ida

Coolis.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70085

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 123

1-98

2. **FULL NAME** Don Vickers

(a) Residence. No. 1109 Jefferson St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 27-1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER Don Samuel Vickers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Edna Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Don S. Vickers 1109 Jefferson St Boise Idaho

15. Filed 4-29, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth to ....., 19.....
that I last saw h..... alive on 4/29, 1930
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Congenital heart, pronounced systolic murmur.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Observed

(Signed) A. J. Coolis, M. D.
4/29, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr. 29 1930

20. Undertaker: Dunmers & Kreb — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Budge

DO NOT WRITE IN THIS SPACE
State File No. 70086

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 223

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eunice Fortin Foster

(a) Residence. No. 1120 Fifteen St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb-4-1913.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	2	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student Boise
(b) General nature of industry, business, or establishment in which employed (or employer) High School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS

10. NAME OF FATHER John W Foster

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Rose Fortin

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) John W Foster, R#5 Boise Idaho

15. Filed 4-30, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Apr 2, 1930, to Apr 29, 1930
that I last saw her alive on Apr 29, 1930
and that death occurred, on the date stated above, at 119 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis Physical findings + Lab.

(Signed) Alfred Budge Jr. M. D.
Apr 30, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: May 1 1930

20. Undertaker: Summers & Rupe — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70087

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 31

(No. U.S.Vet. Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Tom J. STEVENS

(a) Residence. No. Cascade, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. X yrs. X mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: xx

6. DATE OF BIRTH (month, day and year): 9-4-1889

7. AGE: Years 40, Months 5, Days 0. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Wisc.

PARENTS

10. NAME OF FATHER: John Stephens

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Gairitty

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisc.

14. Informant: M. Cornelius

(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 4-4, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to April 4, 1930

that I last saw him alive on April 4, 1930

and that death occurred, on the date stated above, at 6:45 A.M. m.

The CAUSE OF DEATH* was as follows:

General Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gangrene and multiple abscesses right lung.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F.C.SMITH, Reg.Med.Officer, M. D.

4-4-30, 19 (Address) U.S.Vet.Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hamilton Mont. Date of Burial: Shipped 4-5-30 19

20. Undertaker: Wm McBrabney Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70088

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 34
(No. Star, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

123

2. FULL NAME Warren Lee Kivett.
(a) Residence. No. Eagle, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 27th 1930

7. AGE Years 0 Months 0 Days 17 If LESS than 1 day, ---------- hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eagle, Idaho.

PARENTS
10. NAME OF FATHER Elmer L. Kivett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Lulla Hulse.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon.

14. Informant (Address) Elmer L. Kivett. Eagle, Idaho.

15. Filed 4-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 17, 1930
that I last saw her alive on Apr 12, 1930
and that death occurred, on the date stated above, at 5:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Jaundice - I guess - died befor coming to office very yellow -
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. H. Hall, M. D.
4/14/30, 19 (Address) Star, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 4/14/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70089

Local Registrar's No. 32

2. FULL NAME James RYAN

(a) Residence. No. 1217 Colorado St., Boise, Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. X yrs. X mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. James Ryan

6. DATE OF BIRTH (month, day and year): June 21, 1893

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	9	18	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Quebec

PARENTS

10. NAME OF FATHER: XX

11. BIRTHPLACE OF FATHER (city or town) (State or Country): XX

12. MAIDEN NAME OF MOTHER: XX

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): XX

14. Informant: M. Cornelius

(Address) U.S.Vet. Bureau, Boise, Idaho

15. Filed 4-10, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to April 9, 1930, that I last saw him alive on April 9, 1930, and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Tbc.pul.chr. act.far advanced C.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tbc. Enteritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. C. SMITH, Reg.Med.Off., M. D.

4-10-30, 19 (Address) U.S.Vet.Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4-11-30 19
20. Undertaker: Wm. McBratney	Address: Boise, Idahr

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70090

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 33
(No. U.S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Frederick K. LAMBORN

(a) Residence. No. ... Randolph, Utah ... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: xx

6. DATE OF BIRTH (month, day and year): 7-16-1896

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	5	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: xx
11. BIRTHPLACE OF FATHER (city or town) (State or Country): xx
12. MAIDEN NAME OF MOTHER: xx
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): xx

14. Informant: M. Cornelius
(Address) U. S. Vet. Bureau, Boise, Idaho

15. Filed 4-18, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17, 1930 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13, 30, to April 17, 1930
that I last saw h im alive on April 17, 1930
and that death occurred, on the date stated above, at 8:35 P.M.
The CAUSE OF DEATH* was as follows:
General Toxemia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Streptococcus infection of throat. Laparotomy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 4-8-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. C. SMITH, Reg. Med. Officer M. D.
April 18, 1930 (Address) U.S. Veterans' Bureau, Boise, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier, Idaho — Date of Burial: Shipped 4/18/30, 19

20. Undertaker: Wm. McBratney. — Address: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70091

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 94
(No. 1711 N. 16th street.) NP
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Lovina Shurtz.
(a) Residence. No. 1711 N. 16th Street. St. 164
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Shurtz.

6. DATE OF BIRTH (month, day and year): July 1st 1850

7. AGE: 79 Years | Months: 9 | Days: 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Buffalo, New York.

PARENTS

10. NAME OF FATHER: John Potter.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York.
12. MAIDEN NAME OF MOTHER: Mary Austin.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): New York.

14. Informant (Address): Arthur P. Shurtz. Boise, Idaho.

15. Filed 4 - 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 1st 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to Apr - 1, 1930
that I last saw her alive on March 28, 1930
and that death occurred, on the date stated above, at 1 A.M m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? NP
What test confirmed diagnosis? E. R. Symptoms
(Signed) [signature], M. D.
4/1/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 4/2/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70092

PLACE OF DEATH

County of Ada.
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 96
(No. Gordon Rooms, 9th & Grove St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Shupe
(a) Residence. No. Gordon Rooms, 9th & Grove St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 0 yrs. 0 mos 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) December 5th 1913

7. AGE: 16 Years | Months: 3 | Days: 23 | If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denver, Colo.

PARENTS

10. NAME OF FATHER Clay Shupe.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo.
12. MAIDEN NAME OF MOTHER Vira Holtzclaw
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Colo.

14. Informant (Address) Mrs. W. H. Adams. Burns, Oregon.

15. Filed 4-3, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 28th (Day) 1930, 19 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ----------, 19 ---, to ---------- 19 ~~that I last saw him alive on~~ ---------- 19 ~~and that~~ death occurred, on the date stated above, 11:10A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accute illness brought about through lack of resistance due to night parties and use of liquor. ~~(duration)~~ yrs. mos. ds.

CONTRIBUTORY (Secondary) Above is Coroners Jury Verdict (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No. Date of ---
Was there an autopsy? Yes.
What test confirmed diagnosis? ---
(Signed) W. McBratney - Coroner, ~~M. D.~~
4/3/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery | Date of Burial: 4-3-30 19

20. Undertaker: Wm. McBratney. | Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70093

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 97
(No. Idaho Soldier's Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME John H. Hamilton.
(a) Residence. No. Idaho Soldier's Home. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E. Hamilton.

6. DATE OF BIRTH (month, day and year) April 12th 1847

7. AGE Years 82 Months 11 Days 23 If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Civil War Veteran.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER John Hamilton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) William M. Hamilton. Huston, Idaho.

15. Filed 4-7, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to 4/7, 1930
that I last saw him alive on 4/6, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) Fred O. Pillinger, M. D.
4/7/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cemetery, Nampa, Ida. Date of Burial 4/8/30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10094

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 98
(No. 2617 Heron St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Jane Hart.
(a) Residence. No. 2617 Heron St. St.
(Usual place of abode.)
Length of residence in city or town where death occured 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of August Hart.

6. DATE OF BIRTH (month, day and year) June 28th 1853

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS
10. NAME OF FATHER Robert Nevin.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER -----Stewart.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland.

14. Informant Mrs. Tillie Barber.
(Address) 1512 N. 28th. Boise, Ida.

15. Filed 4-9, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 5, 1930
that I last saw h[illegible] alive on April 5, 1930
and that death occurred, on the date stated above, at 1:30A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) 20 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Biliary Calculi
(duration) 20 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Dr. J. W. Dowrey, M. D.
4/7/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	4-10-30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70095

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 100
(No. Idaho Soldiers Home Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George M Lozier
(a) Residence. No. Idaho Soldiers Home St. 164
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1844

7. AGE Years 86 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of Civil
(b) General nature of industry, business, or establishment in which employed (or employer) War.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) E G Burnet Soldiers Home Boise Ida

15. Filed 4-10, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/2, 1929, to 4/9, 1930
that I last saw him alive on 4/5, 1930
and that death occurred, on the date stated above, at 8A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? ?
What test confirmed diagnosis? Clinical findings
(Signed) Fred A Pettyjohn M. D.
4/9, 1930 (Address) Boise Id

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Apr 11 1930

20. Undertaker Summers & Krebs
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70096

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 101

(No. 1422 East Franklin St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME Mrs. Emma Cox.

(a) Residence. No. 1422 East Franklin St. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 0 yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles D. Cox

6. DATE OF BIRTH (month, day and year) Don't Know.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Thomas Bradley.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant Charles D. Cox.
(Address) Boise, Idaho.

15. Filed 4-10, 30 W. Z. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~- - - -

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70097

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 102
(No. 1502 Dewey St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Allen Shields.
(a) Residence. No. Portland, Oregon. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edel Shields.

6. DATE OF BIRTH (month, day and year) February 2nd 1855

7. AGE Years 75 Months 2 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois.

PARENTS

10. NAME OF FATHER Richard Shields.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Sarah Wilson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) Mrs. Edel Shields. Portland, Oregon.

15. Filed 4-11, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to Apr 10, 1930
that I last saw him alive on Apr 10, 1930
and that death occurred, on the date stated above, at 10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Small Pox

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Alfred Burke E. Jr., M. D.
4/11/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Portland, Oregon. Date of Burial Shipped 4/12/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70098

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 412
(No. 742)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Wood Spencer

(a) Residence. No. 404 Thatcher St. Spokane Wash.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 21, 1854

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mrs Margaret M Hacket 1412 West Augusta Ave Spokane Wash

15. Filed 4-12, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 9, 1930
that I last saw her alive on April 9, 1930
and that death occurred, on the date stated above, at 12:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs & Symptoms
(Signed) O. F. Emmett, M. D.
4-12, 1930 (Address) 319 Eastern Bldg Boise Idaho

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial April 14 1930

20. Undertaker Summers & Trego Address Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6099

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2004
Primary Registration District No. 2004 Local Registrar's No. 49
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Aikman

(a) Residence. No. 1201 Jefferson St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Aikman

6. DATE OF BIRTH (month, day and year) June 26, 1852.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
77	9	16.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Stock Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER James Aikman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant Mrs. Mary Aikman
(Address) 1201 Jefferson St Boise Ida

15. Filed 4-14, 1930 W. F. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to April 12th, 1930
that I last saw h.... alive on April 11, 1930
and that death occurred, on the date stated above, at 5-a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Bladder
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of April 10/30
Was there an autopsy? No.
What test confirmed diagnosis? Biopsy
(Signed) J. Speringer, M. D.
4/13, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Apr 15 1930
20. Undertaker: Summers & Rube — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70100

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 125
(No. 401 South 10th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Willard Malstrom.

(a) Residence. No. Tacoma, Wash. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) March 30th 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	0	13	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springvilla, Utah.

PARENTS

10. NAME OF FATHER Charles Malstrom.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boda Olar, Sweden.
12. MAIDEN NAME OF MOTHER Matilda Edwards.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Plenty Victoria, Australia

14. Informant Earl Malstrom.
(Address) Aberdeen, Wash.

15. Filed 4-16, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13, 1930, to Apr 13, 1930
that I last saw him alive on Apr 13, 1930
and that death occurred, on the date stated above, at 1.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

10 min
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't know
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Washington State
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. H. Brashear M. D.
4/14/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 4/16/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 20101

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 116
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Harvey Tate Rathbone.

(a) Residence. No. 1614. Washington Street. St.
(Usual place of abode.)
Length of residence in city or town where death occured yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

91 B

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October. 21. 1844.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85.	5.	24.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Furniture
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peoria Ill.

PARENTS

10. NAME OF FATHER Ira. W.P. Rathbone.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Sarah White.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant Mrs. G.L. Kahl.
(Address) 1614. Washington St Boise, Idaho.

15. Filed 4-16, 1930 W. E. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 15, 1930, that I last saw him alive on April 15, 1930, and that death occurred, on the date stated above, at 10:10 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration and arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kansas
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory & History

(Signed) W. H. Wahle, M. D.
4/16/30, 19 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Manhattan Kansas.	April. 20. 30
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 20102

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1254 Local Registrar's No. 167

(No. 608½ South 15th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Euphemia McLeod.

(a) Residence. No. 608½ South 15th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 18 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hugh McLeod.

6. DATE OF BIRTH (month, day and year) May 30th 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
81	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland.

PARENTS

10. NAME OF FATHER John McClellan.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland.

14. Informant Robert McLeod.
(Address) Cascade, Idaho.

15. Filed 4-17, 1930 W. H. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14th or 15th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19.. that I last saw ... alive on ..... 19.. and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Found Dead in Bed.
Natural Cause.
Senility
No Physician in attendance. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Lived alone.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Coroner.
(Signed) Wm McBratney, M. D.
4/16/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 4/17/30, 19..

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20103

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruby Jane Lawson

(a) Residence. No. 1206 Bannock St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec-9-1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	8,	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn

PARENTS
10. NAME OF FATHER Park Mitchell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Sarah Summers
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tenn.

14. Informant Beulah Lawson
(Address) 1206 Bannock St, Boise Idy

15. Filed 4-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930 to Apr 17, 1930
that I last saw her alive on Apr 17, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Sclerosed arteries

(Signed) W. L. Frazer, M. D.
April 18, 1930 (Address) 513 Eastman

19. Place of Burial, Cremation, or Removal	Date of Burial
Brunaud Idy	Apr 19 1930
20. Undertaker	Address
Summers & Trefz	Boise Idy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70104

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. [illegible]
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Alida Nunley.
(a) Residence. No. 203 N. 12th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James Preston Nunley.
6. DATE OF BIRTH (month, day and year): January 6th 1879
7. AGE: 51 Years; Months: 3; Days: 7; If LESS than 1 day, ---------- hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Scranton, Pa.

PARENTS

10. NAME OF FATHER: ----- Spangenberg.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: Augusta O.-------
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Don't Know.

14. Informant (Address): Mrs. Alma Schober. Oakland, California.
15. Filed 4-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13th 1930 (Month) (Day) 19.... (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 12, 1930 to Apr 14, 1930
that I last saw her alive on Apr 13, 1930
and that death occurred, on the date stated above, at 3:30 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hydrothorax
(duration) yrs. mos. 1 ds.
18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) T. N. Braxton, M. D.
4/14/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 4/19/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Ida.

RECEIVED MAY 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70105

PLACE OF DEATH
County of Ada
City of Kuna

Registration District No. 124
Primary Registration District No. 2202
Local Registrar's No. 202
(No. 1½ mi. so. Kuna)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Anna K. Harala

(a) Residence. No. ____ St. Roseberry, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of John Harala.

6. DATE OF BIRTH (month, day and year) Dec. 8th 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	62.	3	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10. NAME OF FATHER ____ Kunti

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland

12. MAIDEN NAME OF MOTHER ____

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Finland.

14. Informant Miss Ina Harala
(Address) Roseberry, Idaho.

15. Filed 7-23, 1930 Ray Musselman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to March 21, 1930
that I last saw her alive on March 21, 1930
and that death occurred, on the date stated above, at 6 30p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia, Left lung

(duration) ____ yrs. ____ mos. 4 ds.
CONTRIBUTORY (Secondary) Sarcoma of uterus
(duration) ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Canada Idaho
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C C Beeching M. D.
3-22, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Roseberry - Idaho. Date of Burial 3-24 1930

20. Undertaker: Mrs. Nina M. Talley Address: Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70106

PLACE OF DEATH
County of Adams
City of New Meadows,
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11 B

2. FULL NAME Fred Laverne Hilburn

(a) Residence. No. New Meadows St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of babe

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Meadows, Ida

PARENTS

10. NAME OF FATHER Bert Hilburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Weiser Ida Co
12. MAIDEN NAME OF MOTHER Mildred Ledington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Weiser

14. Informant Bert Hilburn
(Address) Midvale

15. Filed 4/4, 1930 W. M. Braun
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to April 28, 1930
that I last saw h.. alive on April 28, 1930
and that death occurred, on the date stated above, at 11, a. m.
The CAUSE OF DEATH* was as follows:

(duration) — yrs. — mos. 7 ds.
CONTRIBUTORY (Secondary) Mal-nutrition
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. N. Schuyler M. D.
Apr. 29, 1930 (Address) New Meadows

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Meadows	Apr. 29. 1930

20. Undertaker — Address New Meadows

RECEIVED APR 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70107

PLACE OF DEATH

County of Idaho
City of New Meadows.
Registration District No. 71
Primary Registration District No.
Local Registrar's No.
(No. 179)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Viola May Ledington

(a) Residence. No. New Meadows, Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) August, 19, 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
12	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Scholar
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Cambridge Ida.
(State or country)

PARENTS

10. NAME OF FATHER Elijah Calvin Ledington
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Bertha B. Lyons
13. BIRTHPLACE OF MOTHER (city or town) Yellow Springs
(State or Country) Ohio.

14. Informant E. C. Ledington
(Address) New Meadows, Idaho

15. Filed 4/14, 1930 W. M. Brown
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to March, 28, 1930
that I last saw h er alive on March, 28, 1930
and that death occurred, on the date stated above, at 10.30 P. m.
The CAUSE OF DEATH* was as follows:
Burn, involving 2/3 of her body, (clothes caught on fire.)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. N. Schuyler, M. D.
Dec. 29, 1930 (Address) New Meadows

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Meadows,	Mar. 29, 1930
20. Undertaker	Address
Earl Collins	New Meadows

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70108

PLACE OF DEATH
County of Bannock
City of Downey

CERTIFICATE OF DEATH
Registration District No. 83
Primary Registration District No. 2160
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

164

2. **FULL NAME** Matilda Lake

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Lake

6 DATE OF BIRTH (month, day and year): Feb. 29th 1852

7 AGE: Years 77 | Months 11 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lyby Sweden

PARENTS
10 NAME OF FATHER: Hans O. Rosdahl
11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden
12 MAIDEN NAME OF MOTHER: Sissa Torstensen
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Nora H. Lake
(Address) Downey Idaho

15 Filed April 12 1930 Mary C. Coffin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb. (Month) 7 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Old age

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J. J. Hartigan, M. D.
4-11-1930 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Cambridge Ida, Bannock Co.
Date of Burial: Feb. 10 1930

20. Undertaker: None
Address: — —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70109

PLACE OF DEATH
County of Bannock
City of Bancroft

Registration District No. 84
Primary Registration District No. 216
(No. Residence)

Local Registrar's No. 181

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Carl John Lewis Lundgren 90

(a) Residence. No. Bancroft Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Brita Erickson

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	11	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Post Master
(c) Name of employer U. S. Gourrment.

9 BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS

10 NAME OF FATHER Lars Johan Lundgren
11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden.
12 MAIDEN NAME OF MOTHER Elizabeth Johansdotter
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Mrs. Carl J. Lundgren
(Address) Bancroft Idaho

15 Filed Apr 22 - 1930 Mrs. G. I. Fitt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April - 20 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April - 6, 1930, to April 20, 1930,
that I last saw him alive on April - 20, 1930,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Enlarged fatty heart
loss of Consciousness

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? examination

(Signed) G. I. Fitt, M. D.
Apr. 22 - 1930 (Address) Bancroft Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 ~~Place of Burial, Cremation, or~~ Removal	Date of Burial
Lund Idaho.	4/23 - 1930
20. Undertaker	Address
Arthur W. Hall	Pocatello.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70110

PLACE OF DEATH
County of Bannock
City of Grace

Registration District No. 84
Primary Registration District No. 2161
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 180

131

2. FULL NAME Anna Marie Lee

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Ralph Lee

6. DATE OF BIRTH (month, day and year) Mar 4, 1898

7. AGE Years 32 Months No Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) St John Utah

PARENTS
10. NAME OF FATHER John A McIntosh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada
12. MAIDEN NAME OF MOTHER Anna Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St John Utah

14. Informant Ralph Lee
(Address) Grace Ida

15. Filed Apr 19, 1930 Mrs G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Mar 16, 1930
that I last saw her alive on Mar 15, 1930
and that death occurred, on the date stated above, at 12:30a m.
The CAUSE OF DEATH* was as follows: Uremia from Brights disease
(duration) — yrs. — mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) — yrs. — mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) J. E. Ate M. D.
3-17-, 1930 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St John Utah
Date of Burial: Mar 18 30

20. Undertaker: M. W. Hendricks
Address: Preston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RE[illegible] MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70111

PLACE OF DEATH

County of Bannock

City of Lago

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

Local Registrar's No. 179

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

101 B

2. FULL NAME Dot Florence Fowler

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Aug. 26, 1928

7 AGE Years 1 Months 4 Days 27 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lago Idaho

PARENTS

10 NAME OF FATHER John Calvin Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lago Idaho

12 MAIDEN NAME OF MOTHER Sine Swenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Aalborg Denmark

14 Informant Mother
(Address)

15 Filed Apr 19, 1930 Mrs G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1-21-, 1930, to 1-23-, 1930 that I last saw her alive on 1-23-, 1930 and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Brights disease

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph E Otte, M. D.

2-17, 1930 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Grace Ida

Date of Burial: 1-25-1930

20. Undertaker: None

Address: —

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70113

PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

Registration District No. 84

Primary Registration District No. 216

Local Registrar's No. 177

(No. Lava Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME James H. Byington

(a) Residence. No. Lava Hot Springs, Idaho. St.
(Usual place of abode)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Sarah Carr

6. DATE OF BIRTH (month, day and year) April 4, 1865.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	0	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Byington

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Hannah Mullen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. James H. Byington

(Address) Lava Hot Springs, Idaho.

15. Filed April 10, 1930. Mrs. J. J. Fey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6., 1930, to April 7, 1930, that I last saw him alive on April 6., 1930 and that death occurred, on the date stated above, at 10 min to 9 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
with paralysis of right
side & throat complicate.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) 0 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) G. G. Fife, M. D.

4/7/30., 19 (Address) ~~Lava Hot Springs~~ Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lava Hot Springs, Ida.	4/11/30. 19

20. Undertaker Arthur W. Hall — Address Pocatello

451 - WESTLEWIS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70115

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161

Local Registrar's No. 5815

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mabelle Myron

(a) Residence. No. Masonic Hotel St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

9a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 5, 1892

7. AGE: Years 38 | Months 11 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Poc Public Schools

9. BIRTHPLACE (city or town) (State or country): Minn.

PARENTS

10. NAME OF FATHER: H. A. Myron
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Gunhelda Tollefsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Layla Ruth Myron
(Address) Yakima, Wash

15. Filed May 5, 1930, H. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 4 (Month) (Day) 1930

17. I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 3, 1930, that I last saw her alive on May 3, 1930, and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. F. Rood M. D.
May 5, 1930 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Elmwood Mims — Date of Burial: May 6 1930

20. Undertaker: H. L. McHan — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70116

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5814

131

2. FULL NAME Charles McConnell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Unknown.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Dr. J. Ryoung
(Address) Pocatello, Idaho

15. Filed 4/30, 1930. J. Ryoung
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-22, 1930, to 4-30, 1930
that I last saw him alive on 4-29, 1930
and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prostate
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. Ryoung M. D.
4/30, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery | Date of Burial 19

20. Undertaker: H. L. McKan | Address: Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70117

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5813

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 241 North Garfield Ave. Poca., Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

H 6

2. FULL NAME Sarah Gibbs McCrary

(a) Residence. No. 241 North Garfield Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of D. C. McCrary

6. DATE OF BIRTH (month, day and year) October 9, 1889.

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	6	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portage, Utah.

PARENTS

10. NAME OF FATHER Charles T. Gibbs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Sarah R. Thornton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) American Fork, Utah.

14. Informant D. C. McCrary
(Address) Pocatello, Idaho

15. Filed 4/30/30., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 28, 1930
that I last saw her alive on April 28, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus about

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. S. Miller M. D.
4/29/30., 19.... (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portage, Utah.	May 1, 1930
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70118

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5812
(No. St. Anthonys Hospital Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Ellen B. Myers
(a) Residence. No. 1621 North Main St. Poca., Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Norman A. Myers

6. DATE OF BIRTH (month, day and year): April 28, 1903.

7. AGE: Years 27, Months 0, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden, Utah.

PARENTS
10. NAME OF FATHER: Albert E. Bradley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Mary Sullivan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Norman A. Myers
(Address) 1621 North Main St. Poca., Ida.

15. Filed 4/30/30., 19.. J. W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 28, 1930. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1930, to Apr 28, 1930
that I last saw her alive on 4-28, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
chronic nephritis
..... (duration) ..... yrs. 5 mos. ..... ds.
CONTRIBUTORY (Secondary) Uremia
..... (duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
4/30/30., 19.. (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.
Date of Burial: 5/2/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70119

Local Registrar's No. 5811

119

2. FULL NAME Edith Harrison

(a) Residence. No. 1050 - N. 8th St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ira Harrison

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	2	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER Orin McCulloch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Ann McCulloch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mr. Ira Harrison

(Address) 1050 - North 8th Street

15. Filed 5/5, 1930. J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/26, 1930, to 4/27, 1930

that I last saw her alive on 4/27, 1930

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Bowels.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 4

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. P. Leaon, M. D.

4/30, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. View Cemetery

Date of Burial May 4 1930

20. Undertaker H. L. McHan.

Address Pocatello, Ida.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70120

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5816

44a

2. FULL NAME Boyd Wayne Thompson
(a) Residence. No. 230 South Hayes Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 12, 1926.

7. AGE: Years 3, Months 5, Days 13. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Child
(c) Name of employer: At Home

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: M. W. Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Smithfield, Utah.
12. MAIDEN NAME OF MOTHER: Mary Wardle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): West Jordan, Utah.

14. Informant: M. W. Thompson
(Address) 230 South Hayes Ave. Poca.

15. Filed 4/26/30., 19__ [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25, (Day) 1930. (Year) 19__

17. I HEREBY CERTIFY, That I attended deceased from 3-1, 1930, to 4-25, 1930
that I last saw him alive on 4-25, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Acute endocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ac. articular rheumatism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M.D.
4/26/30., 19__ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. Date of Burial: 4/27/30. 19__

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70121

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5809
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME John Walter Young

(a) Residence. No. 645 South Eighth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Lerene Harrison

6. DATE OF BIRTH (month, day and year) March 11, 1902.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	28	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Crane Company
(c) Name of employer Pocatello,

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah.

PARENTS

10. NAME OF FATHER J. W. B. Young

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER Gertrude Watkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden, Utah.

14. Informant Mrs. J. Walter Young
(Address) 645 South Eighth Ave, Poca.

15. Filed 4/26/30., 19__. J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/14/30, 19__, to 4/24/30, 19__
that I last saw h[illegible] alive on 4/24/30, 19__
and that death occurred, on the date stated above, at [illegible] m.
The CAUSE OF DEATH* was as follows:
Uræ. q. B. & app.
acute dilated Stomach
Intes. Tract. obstruction
Interval (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uræ. q. B. & app.
Intestinal obstruction
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Joint Rheum
Did an operation precede death? Yes Date of 4/21/30
Was there an autopsy? Yes
What test confirmed diagnosis? Surgical
(Signed) H. C. Dunn, M. D.
4/26/30., 19__ (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/27/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70122

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5808

92

2. FULL NAME Jose Julida Shoshone
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
35			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad Work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: Dr. Robberts
(Address) Pocatello, Idaho

15. Filed 4/22, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-17, 1930, to 4-21, 1930
that I last saw him alive on 4-21, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows: Mesenteric Thrombosis

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Shoshone Ids.
Did an operation precede death? Yes Date of 4-21-30
Was there an autopsy? Yes
What test confirmed diagnosis? Surgery & autopsy
(Signed) [signature], M. D.
4/22, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello
Date of Burial: 4/23 1930

20. Undertaker: H. L. McHan
Address: Poc. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70123

PLACE OF DEATH
County of Bannock
City of McCammon

Registration District No. 28
Primary Registration District No. 2161
(No. McCammon, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5807

1895

2. FULL NAME Stanley E. Thomas

(a) Residence. No. McCammon, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3, 1917.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	0	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): At School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Downey, Idaho.

PARENTS

10. NAME OF FATHER: John E. Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Prises A. Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: John E. Thomas
(Address): McCammon, Idaho.

15. Filed 4/19, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:
Crushing injury to chest
over Heart
Gas tank explosion (Accident)

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...

(Signed) Arthur W. Hall Coroner, ~~M. D.~~
4/19/30., 19... (Address) Poca., Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spanish Fork, Utah.	4/22/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20124

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5806

(No. 331 Washington Ave. Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

HH

2. FULL NAME Violet C. Scadden

(a) Residence. No. 331 Washington Ave. Poca., St.
(Usual place of abode)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of John Scadden

6. DATE OF BIRTH (month, day and year) October 30, 1893.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Kamas, Idaho.

PARENTS

10. NAME OF FATHER: Joseph Crow
11. BIRTHPLACE OF FATHER (city or town) (State or Country): U. S. A.
12. MAIDEN NAME OF MOTHER: Mary Steed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Farmington, Utah.

14. Informant: John Scadden
(Address): Pocatello, Idaho.

15. Filed 4/19, 1930. J. R. Mooney, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1930, to April 17, 1930
that I last saw her alive on April 14, 1930
and that death occurred, on the date stated above, at 4 30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No. Date of —
Was there an autopsy? No
What test confirmed diagnosis? Phy Exam

(Signed) J. R. Ingram, M. D.
4/18/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/20/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70125

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5805

(No. 815 East Sublett St. Poca., Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

1600

2. FULL NAME Boyde Glenn John

(a) Residence. No. 815 East Sublett St. Poca., St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 17, 1927.

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	7	28	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan, Utah.

PARENTS

10. NAME OF FATHER Jared B. John

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Portage, Utah.

12. MAIDEN NAME OF MOTHER Sarah Baxter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wellsville, Utah.

14. Informant Jared B. John

(Address) 815 East Sublett St. Poca., Ida.

15. Filed 4/16, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930, to A-14, 1930
that I last saw h alive on 4-14, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute intestinal

Influenza (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray, M. D.

4/15/30. 19 (Address) Poca., Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portage, Utah.	4/16/30. 19
20. Undertaker	**Address**
Arthur W. Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70126

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2141
(No. Lynn Bros. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5804

117

2. FULL NAME Robert Lambert

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 30 | Months 0 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Louisianna

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Joe Hamelton
(Address) Pocatello Idaho

15. Filed 4/18, 1930 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 11, 1930
that I last saw him alive on April 11, 1930
and that death occurred, on the date stated above, at 12:50 a.m.
The CAUSE OF DEATH* was as follows:
Peritonitis —
Ruptured appendix
..... (duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (Secondary) Right Lung
Pneumonia (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? yes Date of ap 7
Was there an autopsy? no
What test confirmed diagnosis? operation & Examination
(Signed) [signature], M. D.
4-13-, 1930 (Address) [signature] Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery
Date of Burial: April 13 1930

20. Undertaker: H. L. McHan
Address: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19. RECEIVED MAY 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No. 502 N. 3rd St.)

File No. 58037

Registered No. 70127

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mamie Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Mar (Month) (Day) 1879 (Year)

7. AGE: 52 Yrs. Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): St Joseph Mo.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bertha Simpson

(Address) Pocatello Ida

15. Filed Apr 15 1930 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1930 to Mar 11 1930 that I last saw her alive on Mar 3 1930 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) J. H. Lynn M. D.

4/16 1930 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida

DATE OF BURIAL: Apr 16 1930

20. UNDERTAKER: McHan and Co.

ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70128

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 838 W Sublett)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5802

2. FULL NAME Calista R Martin

(a) Residence. No. 838 W Sublett St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

47

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of S H Martin

6. DATE OF BIRTH (month, day and year) August 13th 1879

7. AGE: Years 50 | Months 8 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER S S Redman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant S H Martin
(Address) Pocatello Idaho

15. Filed 4/14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1929, to April 13, 1930
that I last saw her alive on April 10, 1930
and that death occurred, on the date stated above, at 1130 a m.
The CAUSE OF DEATH* was as follows:
Cancer of Right Breast
(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? examination
(Signed) J. L. Lynn, M. D.
4/14/30 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho | Date of Burial: 4-15 1930

20. Undertaker: Schumacher & Beasley | Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70139

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5801
(No. In Hills South of Pocatello, City.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Unknown Man

(a) Residence. No. Unknown St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
About	50			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant A. W. Hall (Coroner)
(Address) Pocatello, Idaho.

15. Filed 4/12, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Exact Date Unknown
About March 21, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Self inflicted
Suicidal
(duration) ____yrs. ____mos. ____ds.

CONTRIBUTORY (Secondary) Found April 11, 1930
By Sheepherder
(duration) ____yrs. ____mos. ____ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner, M. D.
4/12/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/12/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70136

Local Registrar's No. 5800

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 155 South Second Ave. Poca.,)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sanjiro Nakatachi

164

(a) Residence. No. 155 South Second Ave. Poca., Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Arthur W. Hall (Coroner)
(Address) Pocatello, Idaho.

15. Filed 4/11, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Strangulation
Hung Himself
(Suicidal)
... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) Arthur W. Hall Coroner M. D.
4/10/30., 19... (Address) Poca., Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	4/13/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70131

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5799

49 B

2. FULL NAME Agnes Evert Thurman
(a) Residence. No. 636 North Hayes Ave. Poca., St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Leo F. Thurman

6. DATE OF BIRTH (month, day and year): January 9, 1882.

7. AGE: Years 48, Months 3, Days 0. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Provo, Utah.

PARENTS
10. NAME OF FATHER: John Evert
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Mathilda Flygare
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Leo F. Thurman
(Address) 636 North Hayes Ave. Pocatello, Ida.

15. Filed 4/10, 1930. J. R. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 9, 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Mar, 1930, to Apr 9, 1930
that I last saw him alive on ___, 19___
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis.
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Operation Hysterectomy
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Provo Ut
Did an operation precede death? yes Date of 4/2-30
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. R. Young, M. D.
4/10/30., 19___ (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Provo, Utah. Date of Burial: 4/13/30. 19

20. Undertaker: Arthur W. Hall. Address: Pocatello

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70132

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 63
Primary Registration District No.
Local Registrar's No. 149

(No. ; If death occurred in a hospital or institution, give its name instead of street and number.)

1010a

2. FULL NAME Jay Aland Jacobson

(a) Residence. No. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 13, 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Fred Jacobson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Elizabeth Ellen Aland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs. Fred Jacobson
(Address) Bloomington Ida

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1930 to Apr 12, 1930
that I last saw him alive on Apr 12, 1930.
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pneumonia, L Lb
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings

(Signed) C O Moore M. D.
Apr 15, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Ida	4-15 1930
20. Undertaker	Address
John P Holmes	Bloomington Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70133

Registration District No. 63
Primary Registration District No.
Local Registrar's No. 148

PLACE OF DEATH

County of Bear Lake
City of Bloomington
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roscoe Owen Painter

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mar 2, 1917

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER George W. Painter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Deltha S. Thornock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Deltha S. Thornock
(Address) Bloomington Idaho

15. Filed 4-30, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11, 1930, to Apr 17, 1930
that I last saw him alive on Apr 11, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Diabetis Mellitus
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) C O Moore, M. D.
4/28, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bloomington Idaho	Apr 14 1930
20. Undertaker	Address
John P. Holmes	Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

PLACE OF DEATH

County of Bear Lake

City of Bloomington

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 53

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70134

Local Registrar's No. 147

101a

2. FULL NAME Rachel Elvira Thornock

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Matthew W. Thornock

6. DATE OF BIRTH (month, day and year): Nov 1, 1875

7. AGE: Years 54, Months 4, Days 12. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: William Holme

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Phebe Daniels Dmt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: X Leon Thornock
(Address) Bloomington Idaho

15. Filed 4-30, 1930 Mrs. J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 9, 1930, to Mar 13, 1930 that I last saw her alive on Mar 13, 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar L.H.L.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C O Moore M. D.

3/15, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bloomington Ida

Date of Burial: 3-16 1930

20. Undertaker: John P. Hulme

Address: Bloomington Ida

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70135

PLACE OF DEATH
County of Benewah
City of De Smet

Registration District No. 31
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

101 B

2. FULL NAME Stephen Rodi

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 24, 1865

7. AGE

Years	Months	Days	If LESS than 1 day,
65	0	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Catholic Missionary Brother
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): San Remo, Italy

PARENTS

10. NAME OF FATHER N. N. Rodi
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Rev. Geo. J. Kugler, S.J.
(Address) De Smet, Idaho

15. Filed April 16, 1930. John Post Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 15, 1930
that I last saw him alive on April 15, 1930
and that death occurred, on the date stated above, at 7 P- m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy? No Clinical
What test confirmed diagnosis?
(Signed) J. A. Nelson, M. D.
April 15 - 30 (Address) De Smet Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
De Smet, Idaho	April 16 1930

20. Undertaker	Address
George Schadegg	De Smet, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70136

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 22
Primary Registration District No. 2049
Local Registrar's No. 14

(No. 140)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sebastian Dinnico

(a) Residence. No. Harrison St. Harrison, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER Carmen Dinnico
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Bernidita Capoza
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Mike Dinnico
(Address) Kellogg Idaho

15. Filed 4-28, 1930 Walter Coberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25, 1930, to Apr 26, 1930
that I last saw h[illegible] alive on Apl 26, 1930
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Shock following gunshot wound
of ankle - Shotgun injury - amputation
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Senility - advanced
Morbid atherosclerosis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Springstan Idaho
Did an operation precede death? Yes Date of Apr 25-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) D E Cammell, M. D.
4-27, 1930 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida	April 29 1930
20. Undertaker	Address
Geo E Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70137

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 13

PLACE OF DEATH
County of Benewah
City of St. Maries
(No. Esples Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Lois Elene Aikman

(a) Residence. No. St. Marcia St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fe. Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) 1914 March 24

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	1	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wash.

PARENTS

10. NAME OF FATHER W. E. Aikman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Ella Hay
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash.

14. Informant W. E. Aikman
(Address) St Marys

15. Filed 5-8, 1930 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-17, 1930, to 4-24, 1930
that I last saw her alive on 4-24, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Aortic & mitral regurgitation
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?
(Signed) G. G. Hoppe, M. D.
4/24, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	April 27 1930
20. Undertaker	**Address**
Groff Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70138

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 22
Primary Registration District No. 2019

Local Registrar's No. 12

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Peter Madison

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 5, 1902

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	4	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Peter Madison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Anna Barcen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Elva Hollingsworth
(Address) St Maries

15. Filed 5-8, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-15, 1930, to 4-18, 1930
that I last saw him alive on 4-18, 1930
and that death occurred, on the date stated above, at 10 A.M. m.
The CAUSE OF DEATH* was as follows:

Broken compensation, mitral & aortic regurgitation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G L Gospe, M. D.
4-23, 1930 (Address) St. Maries,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mica Pike Cemetery	August 27 1930
20. Undertaker	**Address**
Geo E Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70139

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. 3rd & College)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

92

2. FULL NAME James Monroe Warren
(a) Residence. No. Saint Maries, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 15, 1872
7. AGE: Years 57, Months 11, Days 5; If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER Hardy Warren
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Elizabeth South
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Sina Sam
(Address) St Maries
15. Filed 5-8, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ___, 19___, to ___, 19___
that I last saw h___ alive on ___, 19___
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Embolism
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. G. Espe, M. D.
4-21, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oaksdale Wash
Date of Burial: April 21 1930
20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70140

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. 6th & Main)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

88B

2. FULL NAME Lucinda Jane Mosley
(a) Residence. No. St Maries Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 78, Months 5, Days 5. If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Findley Ohio
PARENTS
10. NAME OF FATHER: Rev S Essex
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)
14. Informant: O M Mosley
(Address) St Maries Ida
15. Filed 5-1, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-22, 1930, to 4-8, 1930
that I last saw her alive on 4-7, 1930
and that death occurred, on the date stated above, at a m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Influenzal bronchitis
Acute cold (duration) yrs. mos. 18 ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C A Robins, M. D.
4/9, 1930 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries
Date of Burial: April 10 1930
20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17. RECEIVED MAY 14 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 70141
Registered No. 2

1. PLACE OF DEATH
County of Benewah
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 123
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar Sidney Lamberson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... 1 ..... (Year)

7. AGE estimated 71 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wisc.

10. NAME OF FATHER: Oscar Lamberson

11. BIRTHPLACE OF FATHER (State or Country): Dont. Know Thint. Wisc.

12. MAIDEN NAME OF MOTHER: Dont. Know Thint. Wisc.

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know Thint. Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Pansy May Lamberson
(Address) Plummer, Idaho

15. Filed Mch 18 1930 H. G. Jaeger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17th 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from He was Dead When I arved 191..... to ..... 191...
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Accidental Fell from Barn-Loft I was told about 1 P. M. March 16th 30.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Weak Heart
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. J. Huringdon M. D.
..... 19.... (Address) Wooley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Plummer, Ida
DATE OF BURIAL: Mch 18 1930

20. UNDERTAKER: H. G. Jaeger
ADDRESS: Plummer

FORM V. S. No. 5 RECEIVED MAY 14 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 7014
Registered No. .....

Registration District No. 46
Primary Registration District No. 212

1. PLACE OF DEATH
County of Benewah
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theodore A. Rapp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH. Sept. (Month) 28 (Day) 1859 (Year)

7. AGE 70 Yrs. 6 Mos. 16 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) Self.

9. BIRTHPLACE (State or Country) Princeton Ill.

10. NAME OF FATHER Henry Rapp

11. BIRTHPLACE OF FATHER (State or Country) Princeton, Ill.

12. MAIDEN NAME OF MOTHER Susannah Eshenfelter

13. BIRTHPLACE OF MOTHER (State or Country) Princeton, Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. A. Rapp
(Address) Plummer Idaho

15. Filed apr. 15 1930 H. L. Jaeger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH apr. (Month) 13 (Day) 1929 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1930 to April 13 1930 that I last saw h.. alive on Jan 25 1930 and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:
chronic nephritis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) arteriosclerosis
(Duration) 10 Yrs. ..... mos. ..... ds.

(Signed) H. E. Wheeler M. D.
April 1930 (Address) Fernwell Bldg Spokane

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Plummer Ida. ....yrs. ....mos. ....days. In the State 21 yrs. 7 mos. 8 days
Where was disease contracted if not at place of death? Plummer Ida
Former or usual residence Plummer Ida.

19. PLACE OF BURIAL ~~OR REMOVAL~~ Plummer Ida — DATE OF BURIAL apr. 16 1930

20. UNDERTAKER H. L. Jaeger — ADDRESS Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. RECEIVED MAY 7 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Sterling

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 70144

Registered No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Wallace Patten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug. 13. 1867. (Month) (Day) (Year)

7. AGE: 62 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Provo, Utah

10. NAME OF FATHER: Thos. J. Patten

11. BIRTHPLACE OF FATHER (State or Country): Inda.

12. MAIDEN NAME OF MOTHER: Johanna Hollister

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah T. Patten

(Address) Sterling, Ida.

15. Filed Mar. 14 1930 Wm Walter E. Patten
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April, 3, 1930/19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., to ..... 19 .....

that I last saw h ..... alive on ..... 19 .....

and that death occurred on the date stated above, at 10:30P.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic.

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pyorhoea, Chronic, and recuring Indigestion.

(Duration) 4 Yrs. ..... mos. ..... ds.

(Signed) Ray McClellan XXX

4-4-1930 (Address) County Coroner, Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo, Utah.

DATE OF BURIAL: 4-8- 1930

20. UNDERTAKER: Modern Mortuary By Arthur W. Hall

ADDRESS: Blackfoot. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70145

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51.

129

2. FULL NAME Cora E. Inskeep.
(a) Residence. No. Pingree St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.
5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of V. D. Inskeep
6. DATE OF BIRTH (month, day and year) Dec 28 1882
7. AGE Years 47 Months 3 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER George Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Eliza Ruff.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Emma Cushman
(Address) Pingree, Ida.
15. Filed Apr 5, 1930 Wm Walter E. Calvin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-27, 1930, to 4-4, 1930
that I last saw her alive on 4-3, 1930
and that death occurred, on the date stated above, at 6:30 A.m.
The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis & chronic myocarditis with Hypertension. (duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? physical findings
(Signed) J. O. Humphrey, M.D.
4-4 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Riverside Thomas. Date of Burial April 6 1930
20. Undertaker E. T. Peck Address Blackfoot

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 7 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Bladkfoot.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. W. Center, Jeanne Add St.)

File No. 70146

Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rozina E. Chittenden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July. 23. 1867 (Month) (Day) (Year)

7. AGE: 62 Yrs. 8 Mos. 11 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James H. Hill

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Salley Hadlock

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Syrwa Chittenden

(Address) Blackfoot. Ida

15. Filed Apr. 4 1930 Mrs Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April - 4 - 1930 (Month) (Day) (Year)

57

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1930, to Apr 4 1930 that I last saw her alive on Apr 4 1930 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) Several Years ds.

Contributory (Secondary) not definately known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

4-7-30 (Address) Blackfoot. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem.

DATE OF BURIAL: 4-7-30 19

20. UNDERTAKER: Modern Mortuary, Blackfoot. Ida.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 25 M. 1-19

RECD MAY 7 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7047

Registered No. 53

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. E. Pacific No. 501. St.)

Registration District No. 121

Primary Registration District No. 1007.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvia Ardelle Gibby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Apr. 7. 1930 (Month) (Day) (Year)

7. AGE: 1 Yrs. Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER David E. Gibby

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER OLive E. White

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D E Gibby
(Address) Blackfoot. Ida.

15. Filed Apr 7 1930 Mrs Nature E Steele
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 163
Apr. ~~Mar.~~ 6. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Was dead when I arrived
that I last saw h alive on 19,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Asphyxiated under
Cover.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W W Beck M. D.
4/7 1930 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cem	4-8-3 19
20. UNDERTAKER Modern Mortuary	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2 #6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70148

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 54

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Bertha Harper Cobbley

(a) Residence. No. Blackfoot, R.F.D.#3 St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George T. Cobbley

6. DATE OF BIRTH (month, day and year): Dec. 4, 1881

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	4	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Pleasent View, Utah

PARENTS

10. NAME OF FATHER: Alfred W. Harper

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Melissa Walker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Geo. T. Cobbley
(Address) Blackfoot, R.F.D.#3

15. Filed Apr 11, 1930 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) — 9 (Day) — 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 - 5, 1930, to 4 - 9, 1930

that I last saw her alive on 4 - 8, 1930

and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary): Chronic nephritis with Hypertension

..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical & clinical tests

(Signed) J O Humphrey M. D.

4 - 10, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery — Date of Burial: Apr. 13, 30

20. Undertaker: E.T.Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70149

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

(No. West Bridge Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

44

2. FULL NAME John Neider

(a) Residence. No. Blackfoot, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Neider

6. DATE OF BIRTH (month, day and year): July 2, 1864

7. AGE: Years 65, Months 9, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bloomington, Ill.

PARENTS

10. NAME OF FATHER: William Neider

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Martha Stedman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scott, Co. Verginia

14. Informant: Charles D. Neider
(Address) Springfield Idaho

15. Filed Apr. 15, 1930 Mr Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 30, 1930, to April 12, 1930 that I last saw him alive on April 12, 1930 and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach & of Lip & Cervical region.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) operated on lip & neck developed in fection.

(duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 3-11-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab.

(Signed) J. D. Houghton, M. D.

4-14, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery

Date of Burial: Apr. 15, 30 19

20. Undertaker: G T Peck

Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70150

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

74a

2. FULL NAME THOMAS BROWN

(a) Residence. No. ..... St. LANARK, BEAR LAKE COUNTY
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) SCOTLAND

PARENTS

10. NAME OF FATHER -------

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---------

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant James V. Torey Att.
(Address) Blackfoot, Idaho.

15. Filed April 15, 1930 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12th, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1927, 19 to Apr. 12-1930, 19
that I last saw him alive on Apr 12th 1930, 19
and that death occurred, on the date stated above, at 10:30 p m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Apr 13th 1930, 19 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~ or Removal: Paris Idaho | Date of Burial 19

20. Undertaker: Modern Mortuary | Address: Blackfoot

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70151

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 57
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

120

2. FULL NAME ROSCOE EWARDS

(a) Residence. No. ..... St. Boise
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) ITALY

PARENTS

10. NAME OF FATHER ----

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ------

12. MAIDEN NAME OF MOTHER -----

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) -----

14. Informant Fred Hayes Att.
(Address) Blackfoot

15. Filed April 25 1930 Mrs Helen E. Calvin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 24th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..., to Apr 24th, 1930, 19...
that I last saw him alive on Apr 24th 1930, 19...
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Syphilis

Don't know (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Don't know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.
Apr 25th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
ASYLUM CEMETARY	Apr 25 1930

20. Undertaker Morris Bluk. Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70152

PLACE OF DEATH

County of Bonner

City of Broten

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

9/B

2. FULL NAME Frank Loren Putney

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada E. Putney

6. DATE OF BIRTH (month, day and year): April 24, 1856

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	11	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Conneaut Ohio

PARENTS

10. NAME OF FATHER: Loren Putney

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Caroline C. Payne

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Ada E. Putney
(Address) Broten, Idaho.

15. Filed April 3, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19..., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:
Pericarditis

..... (duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Floyd G. Wendle, M. D.

Apr. 3, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashland, Nebraska — Date of Burial: Apr. 4 1930

20. Undertaker: Moon Mortuary — Address: Sandpoint, Idaho.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70153

PLACE OF DEATH

County of Bonner

City of Kootenai

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 34

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Solomon David Hibbard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Hibbard

6. DATE OF BIRTH (month, day and year) Jan. 1, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	3	10	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Leon Hibbard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Frank Hibbard
(Address) Kootenai, Idaho.

15. Filed April 7, 1930 Viola Allen, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 5, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1930, to Apr 5, 1930
that I last saw h~~im~~ alive on Apr 4, 1930
and that death occurred, on the date stated above, at 5 30 A m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.
Apr. 7, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Apr. 8, 1930
20. Undertaker	**Address**
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70154

Local Registrar's No. 35

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edwin Grant Coleman

(a) Residence. No. Sandpoint, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lucy Coleman

6. DATE OF BIRTH (month, day and year) Mar. 6, 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	1	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Probate Judge
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pilot Grove, Ill.

PARENTS

10. NAME OF FATHER Chas. Coleman,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Nancy Huckins.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Lucy Coleman.
(Address) Sandpoint, Idaho.

15. Filed April 7, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 1927, to Apr-6, 1930
that I last saw him alive on Apr-6, 1930
and that death occurred, on the date stated above, at 1457 m.

The CAUSE OF DEATH* was as follows:
Cardio Vascular renal disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical

(Signed) Floyd Wendle, M. D.
April 7, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery.	Apr. 8 1930
20. Undertaker	Address
L. G. Moon	Sandpoint, Ida

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70155

PLACE OF DEATH

County of Bonner
City of Selle
Registration District No. 18
Primary Registration District No. 2155
(No.)
Local Registrar's No. 37

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Norlen

(a) Residence. No. Selle St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sophie Norlen

6. DATE OF BIRTH (month, day and year) April 3 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	0	11	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Andrew Gulbrandsen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Ingeborg Pearson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Sophie Norlen
(Address) Selle, Idaho

15. Filed April 17 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13, 1930, to Apr 14, 1930
that I last saw him alive on Apr 13, 1930
and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral arterio-sclerosis (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.

Apr 16, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	April 17 1930
20. Undertaker Turnbull Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70156

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 38
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Henry Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Johnson

6. DATE OF BIRTH (month, day and year) April 25, 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER C. C. Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Eliza Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant A. W. Johnson
(Address) Colburn, Idaho.

15. Filed April 17, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 16, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Apr-16, 1930
that I last saw him alive on Apr-16, 1930
and that death occurred, on the date stated above, at 2:55 a. m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Michigan
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) Floyd G. Wendle, M. D.
4-17, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Colburn, Idaho.	Apr. 18, 1930
20. Undertaker	**Address**
MOON MORTUARY	SANDPOINT, IDAHO.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70157

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 39
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles E. Davis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Davis

6. DATE OF BIRTH (month, day and year) Unk

7. AGE Years 68 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Day
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant L. A. Moon
(Address) Sandpoint, Idaho

15. Filed April 22, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18th, 1930, to April 20, 1930
that I last saw him alive on April 19th, 1930
and that death occurred, on the date stated above, at 6.30 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R. B. Evans, M. D.
April 21, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery | Date of Burial Apr. 23 1930

20. Undertaker M. E. Wessa | Address Priest River, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70158

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 40

(No.) 148a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Sponagel

(a) Residence. No. St. Jamestown, N. D.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 24			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant L. G. Moon
(Address) Sandpoint, Idaho

15. Filed April 23, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 12:25 P m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism by
Railway Train

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. G. Moon Coroner
Apr. 23, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Jamestown, N. D.	

20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70159

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 36

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mary Ella Reever.

(a) Residence. No. 405 S. Second Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. 11 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21, 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	7	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho.

PARENTS

10. NAME OF FATHER Alva Pinkney Reever
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clark, Wash.
12. MAIDEN NAME OF MOTHER Mary Lambert.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Marysville Wash.

14. Informant Alva P. Reever
(Address) Sandpoint Idaho.

15. Filed April 10, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 8, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1930, to April 8 1930
that I last saw her alive on April 8, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Floyd A. Wenzel, M. D.
April 10, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emerald Cemetery	Apr. 11, 1930

20. Undertaker Moon Mortuary Address Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70160

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonner
City of Priest River

Registration District No. 85
Primary Registration District No. 2185
(No. Priest River Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Mary Wiles

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Wiles

6 DATE OF BIRTH (month, day and year): Unknown

7 AGE: About 74 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George McCombs
(Address) Priest River Idaho

15 Filed Apr 10, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 7, 1930 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 7, 1930, that I last saw her alive on April 7, 1930, and that death occurred, on the date stated above, at 7 P.M. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) L. J. Stauffer M. D.
April 9, 1930 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pacific, Missouri
Date of Burial: 19

20. Undertaker: Moon Mortuary
Address: Priest River

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 29161

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonner Registration District No. 85

City of Priest River Primary Registration District No. 2185

(No. .....)

Local Registrar's No. 5

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

4 8 83

2. FULL NAME William Wiles

(a) Residence. No. ..... St. .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Wiles

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George McCombs

(Address) Priest River Ida

15 Filed April 10, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 4, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 4, 1930, that I last saw h. alive on April 3, 1930, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) one yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. J. Stauffer, M. D.

April 7, 1930 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	Apr. 10 1930
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70162

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2107
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

15

2. FULL NAME Mary Kidd
(a) Residence. No. Sugar City, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Addison Kidd

6. DATE OF BIRTH (month, day and year): Sept. 10 - 1876

7. AGE: 54 Years | Months: 6 | Days: 1 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Jackson, Kentucky

PARENTS

10. NAME OF FATHER: Owens Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Matilda Puckett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant
(Address)

15. Filed Mar 3, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Mch 1, 1930
that I last saw her alive on Mch 1, 1930
and that death occurred, on the date stated above, at ___ m.
The CAUSE OF DEATH* was as follows:
Osteomyelitis fibulae (both)
(duration) 30 yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary): Pernicious Anemia
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Sugar City, Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Laboratory & X Ray
(Signed) [signature], M. D.
___, 19___ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City. Date of Burial: Mar 4 1930
20. Undertaker: Vern J. Keller. Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70163

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 214-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

164

2. FULL NAME Nina Maria Peterson
(a) Residence No. Ucon, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew C. Peterson

6. DATE OF BIRTH (month, day and year) May 22, 1851

7. AGE Years 78 Months 9 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs Lee S. Robinson
(Address) Ucon Idaho

15. Filed Mar 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12-30 P m.
The CAUSE OF DEATH* was as follows:
Arthritis Deformans
Old age
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? History from relatives
(Signed) Dr. [signature] Coroner
Mar. 4, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ucon, Idaho
Date of Burial March 4 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70164

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 47

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME James James
(a) Residence. No. Lomax + 1st St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 18 - 1835

7. AGE: Years 94 | Months 2 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Louisville Ky.

PARENTS
10. NAME OF FATHER: Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Joe Keller
(Address) Idaho Falls Ida.

15. Filed Mar 5, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1930, to Mar. 5, 1930
that I last saw him alive on Mar. 5, 1930
and that death occurred, on the date stated above, at 7.15 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Chronic nephritis
and arteriosclerosis (duration) Indefinite

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Mellar M. D.
Mar. 5, 1930 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 3/7 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70165

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 12150
Local Registrar's No. 44
(No. E. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Jackie Dyer
(a) Residence. No. ~~3~~ St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. 1 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 19-1925

7. AGE: Years 5, Months 1, Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS

10. NAME OF FATHER: J. R. Dyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Georgia
12. MAIDEN NAME OF MOTHER: Ora Byers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

14. Informant: J. R. Dyer
(Address) Idaho Falls Ida.

15. Filed Mar 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 6 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 6, 1930
that I last saw her alive on March 6, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Acute lobar Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Acute appendicitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of March 1-30
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
Mar 7, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 3/9 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70166

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

90

2. FULL NAME Geo W Stevens

(a) Residence. No. Ada St. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~Mary Ann~~ Stevens (or) WIFE of Lucinda Violate

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lorado Old Mexico

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Old Mexico
12. MAIDEN NAME OF MOTHER: Mary Ann Stevens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Lucinda Violate Stevens
(Address) Idaho Falls Ida.

15. Filed Mar 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Sept 8, 1929
that I last saw him alive on Sept 8, 1929
and that death occurred, on the date stated above, at 310 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? .....
(Signed) H. D. Spencer, M. D.
Mar 10, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho
Date of Burial: Mar 12 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76167

PLACE OF DEATH
County of Bonneville
City of Ford

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 7-0

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Henry Nephi Stephens

(a) Residence. No. Ford, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline Evans Stephens

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 77 | Months 5 | Days 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kent, England

PARENTS

10. NAME OF FATHER: Isaac Stephens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Francis Dennis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Frances Jessop
(Address): Millville, Utah

15. Filed May 10, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 4, 1930, to Mar. 8, 1930
that I last saw h[illegible] alive on Mar. 4, 1930
and that death occurred, on the date stated above, at 11-30 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Indefinite
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) Indef. yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John O. Mellor, M. D.
(Address) Idaho Falls Idaho
Mar. 8, 1930.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hyrum, Utah — Date of Burial: May 11 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70169

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. U. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5-3

100a

2. FULL NAME Louise Malone
(a) Residence. No. Thornton, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Malone

6. DATE OF BIRTH (month, day and year) June 29, 1889

7. AGE Years 40 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sublett, Idaho

PARENTS
10. NAME OF FATHER Joseph Chambers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth McGee
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant John A. Malone
(Address) Thornton Idaho

15. Filed Mar 19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 17, 1930
that I last saw her alive on March 17, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Bronch Pneumonia
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Lorenzo, Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? X Ray
(Signed) [signature], M. D.
, 19 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sugar City, Idaho
Date of Burial March 20 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70170

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2100
Local Registrar's No. 54
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME James Thomas George Sheppard
(a) Residence. No. ..... St. Chinook Montana
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lorene Sheppard

6. DATE OF BIRTH (month, day and year) April 27, 1878

7. AGE Years 51 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clay Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newton Utah

PARENTS
10. NAME OF FATHER William Sheppard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Christina Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Lorene Sheppard
(Address) Chinook Montana

15. Filed April 16, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to April 15, 1930
that I last saw him alive on April 15, 1930
and that death occurred, on the date stated above, at 3-05 p m.
The CAUSE OF DEATH* was as follows:
Metastatic Carcinoma of Lung.
(duration) ..... yrs. ..... mos. 4 ds.
(1) CONTRIBUTORY (Secondary) Carcinoma of Stomach 1 year
(2) Ulcer of Stomach (duration) 15 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Montana
Did an operation precede death? Exploratory only yes Date of Apr 2
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
4/17/30 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Marysville, Idaho
Date of Burial April 18 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70171

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 1 0
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V V

71 B

2. FULL NAME Clinton Eugene Ellis
(a) Residence. No. Asgood, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) December 28, 1929
7. AGE Years 1 Months 2 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Asgood, Idaho
PARENTS
10. NAME OF FATHER George W. Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan Utah
12. MAIDEN NAME OF MOTHER Emily Purser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Berryhard Idaho
14. Informant George W. Ellis
(Address) Route #7 Idaho Falls
15. Filed Apr 23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-13 -, 1930, to Mar 21, 1930.
that I last saw him alive on Mar 21, 1930.
and that death occurred, on the date stated above, at 9:23 a m.
The CAUSE OF DEATH* was as follows:
Spinal Meningitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R J Sutton, M. D.
3-23-, 1930. (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, ~~or Removal~~ Date of Burial March 1930
20. Undertaker Jack A Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70172

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

188 e

2. FULL NAME Esther May Ballard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): divorced

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Alonzo Lorenz

6. DATE OF BIRTH (month, day and year) Feb. 10, 1908

7. AGE: Years 22 | Months 1 | Days 26 | If LESS than 1 day, ~~hrs. or~~ ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Meridian Ida

PARENTS

10. NAME OF FATHER Arthur Ballard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Andalusia Ill
12. MAIDEN NAME OF MOTHER Nellie Howry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Towersville Mo.

14. Informant Arthur Ballard,
(Address) Caldwell Ida

15. Filed 4/8, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930, to Apr 6, 1930
that I last saw her alive on April 6, 1930
and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:
Traumatic fracture Skull
Base skull
Auto accident (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P Belknap M. D.
4/6, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal: Meridian Ida
Date of Burial: 4-8 1930

20. Undertaker: B. W. Robison
Address: Meridian Ida

RECEIVED MAY 10 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70173

PLACE OF DEATH
County of Canyon
~~City of~~ Rural

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 41

74a

2. FULL NAME Nancy Anne Browder
(a) Residence. No. Near Melba St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 12-29-1844

7. AGE Years: 85 Months: 3 Days: 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS
10. NAME OF FATHER Henry Aubert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant Mrs Emma Edde
(Address) Melba Ida

15. Filed 4/7, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to Apr 6, 1930
that I last saw her alive on Apr 4, 1930
and that death occurred, on the date stated above, at 2:20 A.m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Uterus sclerosis
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P Bellamy M. D.
Apr 7, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or Removal: Weaubleau Mo. Date of Burial 19

20. Undertaker: F. K. Robinson Address: Nampa Ida

H.P.B

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70174

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 40
(No. Samaritan Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gary Douglas Hatfield

(a) Residence. No. ____ St. ____
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	1	— hrs. — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER Gayle Hatfield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Ila Nolt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) So. Dakota

14. Informant Mrs. Gayle Hatfield
(Address) Nampa, Idaho.

15. Filed 4/6, 1930 Stella Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 - 6 - 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-5, 1930 to 4-6, 1930
that I last saw him alive on 4-6, 1930
and that death occurred, on the date stated above, at 3 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature delivery
Delivered by Caesarean
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) Geo. G. Thomason M. D.
4-6, 1930 (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal: Meridian Idaho — Date of Burial: 3-6 1930
20. Undertaker: Wm. D. Talley — Address: Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70175

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

118B

2. FULL NAME Mary Armstrong
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 11-1820

7. AGE Years: 60 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS
10. NAME OF FATHER: T. A. Golden
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: B. Teeney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Armstrong
(Address): Nampa, Ida

15. Filed 4-8, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1930, to Apr. 5th, 1930
that I last saw her alive on Apr. 3rd, 1930
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows: Intestinal Obstruction
(duration) 0 yrs. 0 mos. 5 ds.
CONTRIBUTORY (Secondary) Carcinoma of the ovary (duration) 0 yrs. 6 mos. 0 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes. Date of Apr. 2nd
Was there an autopsy? Yes.
What test confirmed diagnosis?
(Signed) Geo. A. Kellogg, M. D.
4-10-1930 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa, Idaho
Date of Burial: 4-8-30 1930

20. Undertaker: F. K. Robinson
Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework**, or **At home**, and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases **resulting from childbirth** or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70176

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 54
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

8803

2. FULL NAME William Henry Ross

(a) Residence. No. R F D St. ...
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 1850

7. AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address): A L Kollenborn, Nampa Ida

15. Filed 4-30, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 30-30, 19... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis.
(Information from county Physician)

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? No.
What test confirmed diagnosis? ...
(Signed) Paul L. Cass M. D.
4-30-30, 19... Coroner.
(Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cemetery
Date of Burial: 19

20. Undertaker: F.K.Robinson
Address: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70177

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 53

92

2. FULL NAME Elreno C. Andre

(a) Residence. No. Nampa Ida, St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Negro
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 19, Months 5, Days 25. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: Ed Andre.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Amanda Dodge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Mrs. Andre
(Address) Nampa Ida

15. Filed 4-30, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to Apr 29, 1930
that I last saw her alive on April 29, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
(duration) 2 hours yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthma
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Bellamah M. D.
May 2, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Catholic Cemetery
Date of Burial: April 3 1930

20. Undertaker: F. K. Robinson
Address: Nampa Ida
F K Robinson

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70179

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

74a

2. FULL NAME Francis C. Stone
(a) Residence. No. 723 - 11 ave N St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov 2 - 1858

7. AGE Years 71 Months 5 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Long
(Address) Nampa Ida

15. Filed 4/30, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 - (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to Ap. 25, 1930
that I last saw her alive on Ap. 25, 1930
and that death occurred, on the date stated above, at 11 45 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) Samuel A Swayne M. D.
Ap 29, 1930 (Address) Nampa, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ofa Kohlelawn Date of Burial 4-28 1930

20. Undertaker F K Robinson Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70180

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 50
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leslie W. Brainard

(a) Residence. No. South Jay St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie

6. DATE OF BIRTH (month, day and year) Jan 24 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming Iowa

PARENTS
10. NAME OF FATHER John F. Brainard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Sally A. West
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant L. M. Brainard
(Address) Nampa R 1

15. Filed 4/29, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to Apr. 25, 1930, that I last saw him alive on Apr. 19, 1930, and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Syphilis
(duration) 30 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? don't know
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? yes Blood Wass
(Signed) W C Kelly, M. D.
Apr. 29, 1930 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview Cem	4-27 1930
20. Undertaker	Address
Fred R Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5[illegible] RECEIVED MAY 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ....., ... St.)

File No. 70181

Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orville Lawrence

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 19 (Day) 1911 (Year)

7. AGE: 19 Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ada Co. Idaho

10. NAME OF FATHER: E E Lawrence

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Nina Cunaday

13. BIRTHPLACE OF MOTHER (State or Country): N C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [signature]

(Address) Nampa Idaho

15. Filed 4/23 1930 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 22 (Day) 1930 (Year) 1000

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to 4-22 1930 that I last saw him alive on 4-22 1930 and that death occurred on the date stated above, at 7 40 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary): Influenza

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) [signature] M. D.

4-22-1930 (Address) [signature]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. 6 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho

DATE OF BURIAL: 4-24 1930

20. UNDERTAKER: F. K. Robinson

ADDRESS: Nampa Ide

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70182

PLACE OF DEATH
County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5 8

101 B

2. FULL NAME Everett Allen Phillips

(a) Residence. No. Deer Flat St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 17 1910

7. AGE Years	Months	Days	If LESS than 1 day,
19	9		hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home on farm

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Namna Idaho
(State or country)

PARENTS

10. NAME OF FATHER J.A.Phillips

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Ida Daniels

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mo.

14. Informant Mrs J.A.Phillips
(Address) R.D. Nampa, Ida.

15. Filed 4/19, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 27, 1930, to Apr 13, 1930
that I last saw him alive on Apr. 13, 1930
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinically

(Signed) V C Bellamy M. D.
4-19, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerfayer Cem	4-15-1930

20. Undertaker	Address
F. K. Robinson	Nampa Ida

V C B

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70183

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 47
(No. South Side Boulevard)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Krajnik 90
(a) Residence. No. So. Side Boulevard St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 12. 1922

7. AGE — Years: 7. Months: 5 Days: 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ord. Nebraska

PARENTS

10. NAME OF FATHER: Fred. Krajnik
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Weller. Nebr.
12. MAIDEN NAME OF MOTHER: Mary Troyjan
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Czecho Slavonia

14. Informant (Address): Mr. Fred Krajnik. Nampa, Ida.

15. Filed 4/15, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1, 1930, to 4-13, 1930 that I last saw her alive on 4-13, 1930 and that death occurred, on the date stated above, at 6 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rheumatic fever, Complication heart bruit

(duration) yrs. mos. 14 ds
CONTRIBUTORY (Secondary) Paratyphoid-A.
(duration) yrs. mos. 14 ds

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Blood Test & Symptoms
(Signed) A. E. Robinson, M. D
4-14, 1930 (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal: Robertson-Nampa — Date of Burial: 4-16 1930
20. Undertaker: Mrs. Nina M. Talley — Address: Nampa, Id

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70184

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 46
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

13'

2. FULL NAME John L. Harris
(a) Residence. No. [illegible] St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Ruie E. Harris

6. DATE OF BIRTH (month, day and year) Jan. 23rd

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	2	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Amelia Wheeler
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant (Address): Mrs. M. E. Robinson, Nampa, Idaho

15. Filed 4/15, 1930 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Apr 12, 1930
that I last saw him alive on Apr 12, 1930
and that death occurred, on the date stated above, at 1:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia following Removal of Prostatic Gland.
(duration) yrs. mos. 18 ds

CONTRIBUTORY (Secondary): Chronic Nephritis
(duration) several yrs. mos. ds

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3-27-30
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) V C Bullamp M. D.
Apr 14, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Kohl Lawn-Nampa. Date of Burial: 4-15 1930

20. Undertaker: Wm D. Talley Address: Nampa, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-A—25 M.—1-19.

RECEIVED MAY 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70185

Registered No. 45

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. ..... St.)

Registration District No. 7

Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hugo Joseph Hauser, Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH Sept (Month) 25 (Day) 1919 (Year)

7. AGE 10 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or 45 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Hugo Joseph Hauser, Sr.

11. BIRTHPLACE OF FATHER (State or Country) Colorado

12. MAIDEN NAME OF MOTHER Agnes Corder

13. BIRTHPLACE OF MOTHER (State or Country) Raymond Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Don Bequette

(Address) Nampa Idaho

15. Filed 4/13 1930 Seattle Camp, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18, 1925 to Apr 11, 1930 that I last saw him alive on Apr. 11, 1930 and that death occurred on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:

Diabetes Epileptiform

(Duration) ..... Yrs. ..... mos. 3 hrs. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Don Bequette M. D.

4/11 1930 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 6 mos. 24 days. In the State 10 yrs. 6 mos. 16 days

Where was disease contracted if not at place of death? .....

Former or usual residence Raymond, Ida

19. PLACE OF BURIAL OR REMOVAL Catholic Cemetery

DATE OF BURIAL 4-14 1930

20. UNDERTAKER R. K. Robinson

ADDRESS Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70186

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

47

2. FULL NAME Ida Mary Waller
(a) Residence. No. 9 miles South of Nampa
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Waller

6. DATE OF BIRTH (month, day and year) Jan 27-1868

7. AGE Years 61 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER John M. Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) S. Carolina
12. MAIDEN NAME OF MOTHER Tressa Spence
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) S. Cole

14. Informant J. H. Waller
(Address) Nampa Idaho

15. Filed 4-11, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1930, to April 10, 1930
that I last saw her alive on Ap. 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Carcinoma, primary in breast & metastatic in liver & intestines (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Intestinal Obstruction. (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Samuel A. Swayne M. D.
Ap 17, 1930 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cem — Date of Burial 4-13 1930

20. Undertaker F. K. Robinson — Address Nampa

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70187

PLACE OF DEATH
County of Canyan
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 43
(No.) 144
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Waigand

(a) Residence. No. 307 -2Ave -S St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-1-1902

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Okla.
(State or country)

PARENTS
10. NAME OF FATHER Tom R. Woodward
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Senter
13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Ben Waigand
(Address) Nampa Ida.

15. Filed 4/8, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 8, 1930
that I last saw h alive on April 7, 1930
and that death occurred, on the date stated above, at 2 am m.
The CAUSE OF DEATH* was as follows:
Tubal pregnancy
Hemorrhage.
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 4-7-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Operative
(Signed) Horace Bellhouse M. D.
4/8, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
F. K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70188

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Emeline A Johnson
(a) Residence. No. Parma R.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: E. J. Johnson

6. DATE OF BIRTH (month, day and year): Mch-21-1858

7. AGE: Years 73, Months 0, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Edward Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Louisa Cary
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Mrs Alfred B. Jarvis
(Address) Parma, Ida.

15. Filed 5/10, 1930 Lulu Waldron, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 19 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 19, 1930
that I last saw her alive on April 18, 1930
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J. J. Sarazin, M. D.
April 20, 1930 (Address) Nyssa, Oregon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parma Cem
Date of Burial: Apr-20-1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70189

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005

Local Registrar's No. 42

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Foreman

(a) Residence. No. Huston R 2 Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 11-30

7. AGE	Years	Months	Days	If LESS than 1 day, ¼ ..... hrs. or ..... min.
	- -	- -	- -	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Huston Ida
(State or country)

PARENTS

10. NAME OF FATHER Victor V Foreman

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Postoak Texas

12. MAIDEN NAME OF MOTHER Stella L Cook

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Lebanon Mo.

14. Informant Victor V. Foreman
(Address) Huston Ida R 2

15. Filed 4-21-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11-30 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 11, 1930, to April 11, 1930
that I last saw her alive on April 11, 1930
and that death occurred, on the date stated above, at 7:50 A. m.
The CAUSE OF DEATH* was as follows:
Malnutrition Premature -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? None
(Signed) Robert E Tallard, M. D.
April 14, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	4-12-30 19
20. Undertaker	**Address**
Paul L. Case	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70190

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

92

2. FULL NAME Mrs Candis Amelia Joy

(a) Residence. No. 301 Dearborn St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Joy

6. DATE OF BIRTH (month, day and year) Nov 12, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Calvin Moshier

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Louella Kieth

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Jonh A. Joy
(Address) Caldwell

15. Filed 4-18-, 1930 John S. Meyer, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18-30, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/18/30, 19, to 4/18/30, 19
that I last saw her alive on 4/18/30, 19
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Coronary thrombosis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. W. Montgomery, M. D.
4/18/30, 19 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boulder Colo	19
20. Undertaker	Address
Paul L. Case	Caldwell, Idaho

RECD MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70191

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 44
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ida Billups

(a) Residence. No. Rfd Caldwell St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 23, 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	3	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell

PARENTS

10. NAME OF FATHER W. E. Billups

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mattie Richardson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant W. E. Billups
(Address) R F D Caldwell Idaho

15. Filed 4-21-, 1930. John S. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
—, 19..., to —, 19...
that I last saw her alive on Apl 19, 1930
and that death occurred, on the date stated above, at 11.45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 t yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthma
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) S P Dudley, M. D.
Apl 21, 1930 (Address) Caldwell.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	April 21 1930
20. Undertaker	Address
Paul L Case	Caldwell, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70192

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 45
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert D King
(a) Residence. No. Caldwell #4 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucy M. King

6. DATE OF BIRTH (month, day and year) June 19 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	10	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) LeSueur Minnesota

PARENTS

10. NAME OF FATHER William R. King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) A B King

15. Filed 4-22-, 1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to Apr 19, 1930
that I last saw him alive on Apr. 19, 1930
and that death occurred, on the date stated above, at 6-15 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Senile Hemorrhage
one year ago (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. A. Whittenberger M.D.
Apr. 21, 1930 (Address) Caldwell, Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 4/22 1930
20. Undertaker: C. V. Beckham — Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70193

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 46
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M. Nicholas
(a) Residence. No. R F D Nampa Idaho St. 119
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs John M. Nicholas.

6. DATE OF BIRTH (month, day and year) June 27, 1858

7. AGE Years: 71 Months: 9 Days: 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spanish Forks, Utah

PARENTS
10. NAME OF FATHER John Nicholas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Mary Anne Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wales

14. Informant (Address) Max Nicholas Rfd Caldwell

15. Filed 4-22-1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20, 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 16, 1930, to Apr 20, 1930
that I last saw him alive on Apr 20, 1930
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Strangulated intestines by Faced adhesions —
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Adhesions of Former Operation (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Apr 20/30
Was there an autopsy? No
What test confirmed diagnosis? Operative
(Signed) J D Forrest, M. D.
4/22, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Kohlerlawn, Nampa, Ida
Date of Burial: April 23 1930

20. Undertaker: Paul L Case
Address: Caldwell, Ida

mar. 14-

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70194

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 147
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 (B)

2. FULL NAME Joseph Calloway
(a) Residence, No. Caldwell #4 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of — — — —

6. DATE OF BIRTH (month, day and year) Sept 14 1861

7. AGE Years 68 Months 7 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Cincinnati
(State or country) Ohio

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) Irelands
(State or County)

14. Informant (Address) E. F. Mason Caldwell Ida R.F.D.

15. Filed 4-24- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1930, to Apr. 21 1930
that I last saw him alive on Apr. 21 1930
and that death occurred, on the date stated above, at 11 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paraendemetrous Nephritis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
4-23- 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Cincinnati Ohio
Date of Burial 19

20. Undertaker G. V. Peckham
Address Caldwell Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70195

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 48
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Mae Parmenter
(a) Residence. No. 502 - Fillmore St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 23-1881
7. AGE Years 48 Months 11 Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) North Branch Iowa
PARENTS
10. NAME OF FATHER Andrew Jackson Barney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Minerva Dietrich
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania
14. Informant (Address) H E Parmenter Caldwell Ida
15. Filed 4-28-, 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1930, to Apr. 23, 1930
that I last saw her alive on Apr. 22, 1930
and that death occurred, on the date stated above, at 6-30 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Chr. Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Was Blue baby and had leaking valve since birth
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Tray & Percussion
(Signed) C. M. Haley, M. D.
4-24-, 1930 (Address) Caldwell Ida
19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 4-27 1930
20. Undertaker C. V. Peckham
Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70196

PLACE OF DEATH
County of Canyon
City of Caldwell Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 49
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maurice Hartley
(a) Residence. No. 415 N Kimball St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 16 1848

7. AGE: Years 81 | Months 7 | Days 10 | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER James Arbuckle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Tinke
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant (Address) Mabel D Logan 430 W 27th St Ogden Utah

15. Filed 5-2-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1930 to April 26 1930 that I last saw h alive on April 26 1930 and that death occurred, on the date stated above, at 11-30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Two previous hemorrhages
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Autopsy Physical
(Signed) C. C. Hales M. D.
4-27, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 4-29 1930
20. Undertaker: D. V. Beckham — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

4/24-30

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70197

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 50
(No.) 117
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Annie Krzesnik
(a) Residence. No. Homedale Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE —
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Krzesnik

6. DATE OF BIRTH (month, day and year) July 29-1903

7. AGE Years 26 Months 8 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rocksprings Wyo.

PARENTS
10. NAME OF FATHER John Jesenko
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jugoslavia
12. MAIDEN NAME OF MOTHER Agnes Mercena
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Jugoslavia

14. Informant (Address) Mrs. J. H. Jesenko Homedale Ida.

15. Filed 5-5-, 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1930, to Apr. 29, 1930
that I last saw her alive on April 29, 1930
and that death occurred, on the date stated above, at 1:15 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured Appendix
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Homedale
Did an operation precede death? yes Date Apr. 24-30
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) C. M. Kaley M. D.
4-29-, 1930 (Address) Caldwell Id.

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 5-1 1930

20. Undertaker C. V. Peckham
Address Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70198

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 51

(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank A. George

(a) Residence. No. 1217 Arthur St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 11 1852

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	0	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Broadcaster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Napoleon B. George

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Julia Lindsay

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois

14. Informant (Address) Walter Griffith Caldwell Ida.

15. Filed 5-9-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) - 6 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to May 5, 1930
that I last saw him alive on May 5, 1930
and that death occurred, on the date stated above, at 4-25 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? symptoms

(Signed) W. M. Montgomery M. D.
5/9, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	5/8 - 1930
20. Undertaker E. V. Peckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70199

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

2. FULL NAME John Staats
(a) Residence. No. Soda Springs Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fineda Staats

6. DATE OF BIRTH (month, day and year) May 8 - 1856

7. AGE Years 73 Months 11 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTH[illegible] or town) (State or Country) Germany

14. Informant Clyde Gill
(Address) Soda Springs Idaho

15. Filed 4-15-1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on April 14, 1930
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows: Cystitis Chronic
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hyperlipsy of Prostate
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3/24/30
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) [illegible], M. D.
4-15, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Soda Springs Ida
Date of Burial 4-16-1930

20. Undertaker E. D. Whitman
Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70200

County of Soda Springs
City of Caribou
Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 14
(No. Caribou Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME L. L. Hall

(a) Residence. No. Soda Springs Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: unknown

6. DATE OF BIRTH (month, day and year): unknown

7. AGE: Years: About 70 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C. D. Whitman
(Address) Soda Springs Ida

15. Filed 4-27, 1930 Dr. Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 26, 1930
that I last saw him alive on April 26, 1930
and that death occurred, on the date stated above, at 11:45 a. m.

The CAUSE OF DEATH* was as follows:
Hemiplegia (Paralysis)
(Apoplexy ?)
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Apoplexy
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? Montpelier Ida
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Russell Tigert, M. D.
April 27, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~ or ~~Removal~~: Soda Springs Ida — Date of Burial: April 27 1930

20. Undertaker: C. D. Whitman — Address: Soda Springs Ida

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70991

PLACE OF DEATH
County of Bonneville
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2159
Local Registrar's No. 13
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles S. Ellis
(a) Residence. No. Soda Springs St. Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	11	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Perry Co. Mo.

PARENTS

10. NAME OF FATHER Willis G. Ellis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York State
12. MAIDEN NAME OF MOTHER Margaret Erwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alabama

14. Informant J. W. Ellis Sr
(Address) Soda Springs Ida

15. Filed 3-6-1930 Dr. Russell Tyler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 6 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to March 6, 1930
that I last saw h alive on March 5, 1930
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows: Valvular Heart Disease
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Auscultation
(Signed) Russell Tyler M. D.
3-6-1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 3-7-1930
20. Undertaker E. D. Whiteman — Address Soda Springs Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76202

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 2167
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 93

2. FULL NAME Marie Peterson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9 - 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER L Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs L Blake
(Address) Grangeville

15. Filed 4/30, 19 W A Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1930, to Apr. 29, 1930
that I last saw her alive on April 28, 1930
and that death occurred, on the date stated above, at 6:00 a.m.
The CAUSE OF DEATH* was as follows:

Cholecystitis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Embolism (Cardiac)
Immediate (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Apr. 8, 1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R. I. Hopkins M. D.
4/30/30, 19 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weippe Idaho	May 2 1930
20. Undertaker	Address
W A Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70203

PLACE OF DEATH
County of Clearwater
City of Headquarter

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

188 G

2. FULL NAME Isaac Neimi

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years About 40 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) (State or country) ✓

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant U. A. Shaw Coroner
(Address) Orofino

15. Filed 4/26, 1930. U. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Accidental Killed by falling tree crushing in skull
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) U. A. Shaw Coroner ~~M. D.~~
4/25, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida | Date of Burial: 4/28 19

20. Undertaker: U. A. Shaw | Address: Orofino

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70204

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

77

2. FULL NAME Lydia L. Leonard

(a) Residence. No. ..... St. Bonners Ferry, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Percy Leonard

6. DATE OF BIRTH (month, day and year) August 19, 1889

7. AGE	Years	Months	Days	If LESS than 1 day,
	40	8	0	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Martin V. Buck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Ella M. Sanborn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 4/20, 19.... W. A. Sloan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8, 1930 to April 19, 1930
that I last saw her alive on April 18 1930
and that death occurred, on the date stated above, at 4.15 A. m.
The CAUSE OF DEATH* was as follows:
Exhaustion of psychosis

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Manic-depressive psychosis, mixed type. (duration) ✓ yrs. 3 mos. ? ds.

18. Where was disease contracted ✓ if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McElwain, M. D.
April 19, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Bonner Ferry	
20. Undertaker W. A. Sloan	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70205

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

2. FULL NAME Iver Erickson
(a) Residence. No. ..... St. Spokane Wash 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb 9th 1887

7. AGE: Years 43 | Months 1 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS
10. NAME OF FATHER: John Erickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER: Alma Swenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Swan Erickson
(Address) 4117 - 55 Ave S.E. Portland

15. Filed 4/3, 19.. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2d (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-21-, 1930, to Apr 2nd, 1930
that I last saw him alive on April 2nd, 1930
and that death occurred, on the date stated above, at 2.30 a m.
The CAUSE OF DEATH* was as follows: Heart ~~insuff~~ failure
(duration) Dont Know yrs. mos. ds.
CONTRIBUTORY (Secondary) alcoholism - Pleurisy
pneumonia (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boril, Idaho
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature] M. D.
4/3, 1930 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida
Date of Burial: 4/4 19

20. Undertaker: W D Pinson
Address

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70206

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2197
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

31

2. FULL NAME Lovina Topping

(a) Residence. No. ..... St. Coeur d'Alene, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 7th, 1903

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	0	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Howard, Kansas

PARENTS

10. NAME OF FATHER Philetus C. Topping
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Nancy Worthan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho -

15. Filed 4/3-, 1930 V. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 2, 1927, to April 2, 1930
that I last saw her alive on April 1, 1930
and that death occurred, on the date stated above, at 2.20 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 10 yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Dementia Praecox, hebephrenic type (duration) 7 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John J. McFleming, M. D.
April 2, 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Howard Kansas	19
20. Undertaker	Address
V. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70207

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186 . Local Registrar's No. 99
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Rabenort

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Anton Rabenort

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Martin

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant F. H. Rabenort
(Address)

15. Filed March 1, 1930 Edna M. Kenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2/26, 1930, to 3/1, 1930
that I last saw him alive on 2/25, 1930
and that death occurred, on the date stated above, at 5 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M. D.
March 1, 1930. (Address) Challis Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
May Idaho	Mar. 2 1930

20. Undertaker	Address
Theo Gomez	Mackay Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76208

PLACE OF DEATH
County of Custer
City of Mackay
Registration District No. 76
Primary Registration District No. 2155
Local Registrar's No. 151
(No. 8 1/2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Rose Emma Routh

(a) Residence. No. Mackay, Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	wht	Widowed

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of James Routh

6. DATE OF BIRTH (month, day and year) Jan. 27 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	2	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) x
(c) Name of employer x

9. BIRTHPLACE (city or town) (State or country) Burlington, Iowa

PARENTS

10. NAME OF FATHER John P. Phelps

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant A. L. Reynolds
(Address) Mackay, Idaho

15. Filed 5/10, 1930 Lena Nuxoll Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-8, 1930, to 4-19, 1930
that I last saw her alive on 4-19-30, 1930
and that death occurred, on the date stated above, at 10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

acute myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Conrad A. Jensen, M. D.
19 (Address) Mackay Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mackay, Idaho	
20. Undertaker Theo. R. Garner	Address Mackay Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70209

PLACE OF DEATH
County of Custer
City of Mackay
Registration District No. 76
Primary Registration District No. 2153 Local Registrar's No. 27
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phyllis May Lane
(a) Residence. No. Mackay, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	wht	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of x

6. DATE OF BIRTH (month, day and year) Sept. 1, 1927

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) x
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mackay, Ida

PARENTS

10. NAME OF FATHER Orie Lane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Black Foot Ida
12. MAIDEN NAME OF MOTHER Mildred May Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Salt Lake City

14. Informant x Orie Lane
(Address)

15. Filed 5/10 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4- (Month) 3 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-3, 1930, to 4-5-, 1930
that I last saw her alive on 4-5-30, 19....
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Autopsy
(Signed) C. A. Jensen, M. D.
, 19.... (Address) Mackay Ida

19. Place of Burial, Cremation, or Removal: Mackay, Ida. Date of Burial: Apr. 5 1930
20. Undertaker: Chas. R. Jensen Address: Mackay Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70210

PLACE OF DEATH
County of Franklin
City of Preston Ida

Registration District No. 27
Primary Registration District No. 2119
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

45

2. FULL NAME Kate W. Carter

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Henry Carter

6. DATE OF BIRTH (month, day and year): Oct. 28, 1862

7. AGE: Years 67, Months 5, Days 23. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Thomas Wilmore
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Louise Baldwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Wm. Henry Carter
(Address): Preston, Idaho

15. Filed 4-26, 1930 G. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-29, 1930, to 4-20, 1930
that I last saw her alive on 4-18, 1930
and that death occurred, on the date stated above, at 6:00 P.m.
The CAUSE OF DEATH* was as follows:
Probably Carcinoma of Cecum
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic intestinal obstruction
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. R. Cutler, M. D.
4-24, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston, Idaho — Date of Burial: 4/24/ 19

20. Undertaker: M. W. Hendricks — Address: Preston

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20212

PLACE OF DEATH
County of Franklin
City of Preston Ida

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 48B

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rasmus Caspersen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	6	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Casper Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Dorthea Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant John Wm. Caspersen
(Address) Banida, Idaho

15. Filed 4-21, 1930 C.R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-29, 1929, to 4-19, 1930
that I last saw him alive on 4-16, 1930
and that death occurred, on the date stated above, at 6 00 m.

The CAUSE OF DEATH* was as follows:
Myocarditis
Genral arteriosclevor
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina Pectoris
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C.R. Cutler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	4 20 1930
20. Undertaker	Address
M. W. Hendricks	Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70213

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2114

Local Registrar's No. 129

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Woodward Frew

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Frew

6. DATE OF BIRTH (month, day and year) June 7 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pleasant Grove Utah

PARENTS

10. NAME OF FATHER Wm Woodward

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mable Whittle

(Address) Preston

15. Filed 4-21, 1930. A. P. Peeler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to April 18, 1930
that I last saw her alive on April 15, 1930
and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 3 mos. — ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. W. Stites, M. D.

April 19, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Apr 24 '30

20. Undertaker M. W. Hendricks Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

PLACE OF DEATH

County of Pr. Franklin

City of Preston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2119

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70214

Local Registrar's No. .....

74a

2. FULL NAME Anna Marie Hansen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: whits

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23 1854

7. AGE: Years 75, Months 8, Days 17. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED: None

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10. NAME OF FATHER: O. Rasmuss Olsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Maren Olsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs Frank Collins

(Address) Preston

15. Filed 4-17, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-10, 1930, to 4-10, 1930

that I last saw her alive on 4-10, 1930

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorage

..... (duration) ..... yrs. ..... mos. ..... d

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. .....

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) E. S. Milford

4-11, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOL CAUSES, state (1) MEANS AND NATURE OF INJURY, an whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho Apr 13 30

Date of Burial

20. Undertaker: M.W. Hendricks Preston

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70215

PLACE OF DEATH

County of Franklin

City of Weston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Matilda Karana Schvanveldt

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan II 1920

7. AGE Years 10 Months 3 Days II If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weston

PARENTS

10. NAME OF FATHER Erastus Schanveldt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brigham Utah

12. MAIDEN NAME OF MOTHER Mary Philipps

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brigham Utah

14. Informant Erastus Schvanveltd
(Address) Weston

15. Filed , 19 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Apr. 22, 1930
that I last saw her alive on Apr. 21, 1930
and that death occurred, on the date stated above, at 5 30 a m.
The CAUSE OF DEATH* was as follows:
Acute Brights disease
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 15 ds.

18. Where was disease contracted, if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
Apr. 23, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Weston Idaho
Date of Burial Apr 25 1930

20. Undertaker M. W. Hendricks Prston
Address

M

FORM V. S. No. 5-25 M. 1-19.

MAY 5 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70216

Local Registrar's No.

1. PLACE OF DEATH

County of Franklin

City of Weston, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. - St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allen Lee Davis

161a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: April 4-1930 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Weston, Ida

10. NAME OF Father: Louis A Davis

11. BIRTHPLACE OF FATHER (State or Country): Weston, Ida

12. MAIDEN NAME OF MOTHER: Leta Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Weston, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis A Davis

(Address) Weston, Ida

15. Filed Apr 5 1930

A. R. Waller
L. S. Price
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4-1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1930, to Apr 4 1930, that I last saw him alive on Apr 4 1930, and that death occurred on the date stated above, at 8:25 a M.

The CAUSE OF DEATH* was as follows:

a premature infant in 6 month of gestation (a twin)

(Duration) ..... yrs. ..... mos. ✓ ds.

Contributory (Secondary) ✓

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Slater M. D.

19 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dayton, Ida

DATE OF BURIAL: Apr 5 1930

20. UNDERTAKER: H Hendricks

ADDRESS: Preston, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Weston, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

State File No. 70217

Local Registrar's No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Marie Davis

1610

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: April 4-30 1 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 20 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Weston, Ida

10. NAME OF Father: Louis A Davis

11. BIRTHPLACE OF FATHER (State or Country): Weston, Ida

12. MAIDEN NAME OF MOTHER: Leta Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Weston, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis A Davis

(Address) Weston, Ida

15. Filed Apr 5 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4 -1930 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4 1930, to Apr. 4 1930, that I last saw her alive on Apr. 4 1930, and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Premature infant in 6 month of gestation - (a twin)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ✓

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Slates M. D.

..... 19 ..... (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dayton, Ida

DATE OF BURIAL: Apr 5 1930

20. UNDERTAKER: Hendricks

ADDRESS: Preston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70218

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

R6

2. FULL NAME Absalom D. Burris

(a) Residence. No. Logan, Utah, St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Quaryman

(b) General nature of industry, business, or establishment in which employed (or employer) employed with the Franklin Sugar Co.

(c) Name of employer Franklin County Sugar Co.

9. BIRTHPLACE (city or town) (State or country) Preston, Idaho,

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Logan, Utah,
(Address)

15. Filed 4-21, 1930 A. R. Butler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 20 (Day) 193 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 3:30 P m.

THE CAUSE OF DEATH* was as follows: Instant death - Killed by slide in rock quarry.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Inspection

(Signed) Don Hanson, M. D.

April 20, 1930 (Address) Coroner

Witnesses John Dursteler Ethel Oliverson

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70219

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 29
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

133

2. FULL NAME Hendrick Jensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jensen

6. DATE OF BIRTH (month, day and year) Jan. 12 1841

7. AGE Years 89 Months 3 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER MOTHER Johanna Larsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Deanmrk

12. MAIDEN NAME OF MOTHER FATHER Jense Christensen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Den mark

14. Informant Mary Jensen
(Address) Preston Idaho

15. Filed 4-17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-2, 1930, to 4-13, 1930
that I last saw her alive on 4-12, 1930
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows:
Acute cystitis 1 wk.
Chronic Carditis 4 yrs
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
4-16, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Preston Idaho Date of Burial Apr 17 1930

20. Undertaker M. W. Hendricks Address preston

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70220

PLACE OF DEATH
County of Fremont
City of Chester
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 328
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Edward Williams Schoenfeld

(a) Residence. No. ..... Chester, Idaho ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXX

6. DATE OF BIRTH (month, day and year) March 6th, 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	One	~~XXX~~ 3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah.

PARENTS

10. NAME OF FATHER James T. Schoenfeld
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Winnie Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant James T. Schoenfeld
(Address) Chester, Idaho

15. Filed ~~MAR~~ April 9th, 1930 W. M. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1930, to Apr. 9, 1930
that I last saw him alive on Apr. 8, 1930
and that death occurred, on the date stated above, at 2: 4. m.
The CAUSE OF DEATH* was as follows:
Broncho- Pneumonia
..... (duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Meningitis (Pneumococcal
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A. K. Sutherland, M. D.
4-9, 1930 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City, Utah	11th, 1930

20. Undertaker	Address
W. M. Hansen	St. Anthony, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70231

Local Registrar's No. 327

PLACE OF DEATH

County of Fremont Registration District No. 99

City of St. Anthony, Ida Primary Registration District No. 2177

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

159

2. FULL NAME Infant - not named

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day and year) Mar. 28, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Anthony, Ida.

PARENTS

10 NAME OF FATHER Otto L. Jensen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hyrum, Utah

12 MAIDEN NAME OF MOTHER Jennie Durney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Thayne, Wyo.

14 Informant Otto L. Jensen

(Address) St. Anthony, Ida.

15 Filed Mar. 29, 1930 Clerk Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1930, to Mar. 28, 1930, that I last saw him alive on Mar. 28, 1930, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Malformation
Excessive goitre.

Life (duration) — yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Findings

(Signed) P. M. Kellogg, M. D.

3-28-, 1930 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	Mar 29 1930
20. Undertaker None	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70223

PLACE OF DEATH

County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 375

(No. 1000)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grant Hyrum Jensen

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) St. Anthony
(State or country) Idaho

PARENTS

10. NAME OF FATHER Otto L. Jensen
11. BIRTHPLACE OF FATHER (city or town) Hyrum
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Jennie Gadsenney
13. BIRTHPLACE OF MOTHER (city or town) St. Anthony
(State or Country) Idaho

14. Informant Otto L. Jensen
(Address) St. Anthony Idaho

15. Filed Feb. 21, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 21 at
(Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to Feb. 21, 1930
that I last saw him alive on Feb. 19, 1930
and that death occurred, on the date stated above, at 2:15 A. m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Findings

(Signed) P. M. Kelly, M. D.
2-21- 1930 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	Feb 23 1930

20. Undertaker C. W. Hansen Address St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 19 1930

PLACE OF DEATH

County of Fremont

City of Salem North

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70224

Local Registrar's No. 324

74a

2. FULL NAME Florilla Ann Fullmer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. C. Fullmer

6. DATE OF BIRTH (month, day and year) Dec. 6. 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69.	2	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moonie Utah.

PARENTS

10. NAME OF FATHER Erastus Curtis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgetown Ohio.

12. MAIDEN NAME OF MOTHER Mary C. Barton.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Delaware

14. Informant J. C. Fullmer.
(Address) Rexburg Route #2

15. Filed 2/14, 1930 Wm. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1930, to Feb. 14, 1930
that I last saw her alive on Feb. 13, 1930
and that death occurred, on the date stated above, at 4a m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis & Hypertension

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? no -
What test confirmed diagnosis?
(Signed) J. D. Ellison, M. D.
Feb. 15, 1930 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City Cem	Feb. 17th 1930
20. Undertaker	Address
Geo. D. Keller	Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76226

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Henry Bennett

(a) Residence. (No.) St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Viola Dolores Bennett

6. DATE OF BIRTH (month, day and year) Mar 23 - 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	-	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Cedar Fork
(State or country) Utah

PARENTS

10. NAME OF FATHER Eli Bennett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Bessie Berry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Viola Bennett
(Address) Emmett Idaho

15. Filed 4/5, 1930 J K Reynolds
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from only 19 to saw him after 19
that I last saw him alive on 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Probably, Angina Pectoris
This fellow died very suddenly
before medical attendant
reached him (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J K Reynolds M. D.
4/5, 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	4/8 1930
20. Undertaker C O Buckmann	Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70227

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 N

2. FULL NAME Edward William Morehouse

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Maud Morehouse

6. DATE OF BIRTH (month, day and year) Sept 5 - 1873

7. AGE: Years 56 | Months 7 | Days 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Martin D. Morehouse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Selina Robinson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Mrs Maud Morehouse
(Address) Emmett Idaho

15. Filed 4/26, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 23, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Broken neck caused by being thrown from a runaway wagon. Was dead when I arrived (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R N Cummings, M. D.
4/26, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 4/27 1930

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70228

PLACE OF DEATH
County of Ada
City of Emmett

Registration District No. 4
Primary Registration District No.
Local Registrar's No.

(No. 440)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl A. Anderson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4 - 1905

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett
(State or country) Idaho

PARENTS

10. NAME OF FATHER Charles Anderson
11. BIRTHPLACE OF FATHER (city or town) Pittsburg
(State or Country) Penn.
12. MAIDEN NAME OF MOTHER Lulu E. Monroe
13. BIRTHPLACE OF MOTHER (city or town) Topeka
(State or Country) Kansas

14. Informant C. L. Anderson
(Address) Emmett Idaho

15. Filed 4/26, 1930 J. H. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
June, 1928, to April 24, 1930
that I last saw h-- alive on April 23, 1930
and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:
Endo-Carditis following
acute Rheumatism
following septic throat
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bad tonsils
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) , M. D.
4/26, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	4/27 1930

20. Undertaker C. D. Bucknum
Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70229

PLACE OF DEATH
County of Gem
City of Montour

Registration District No.
Primary Registration District No.
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mr Manford LeRoy Seits

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Elizabeth Seits

6. DATE OF BIRTH (month, day and year) Aug. 2 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Garage man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion Co. Oregon

PARENTS

10. NAME OF FATHER Abraham Seits
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary Ellen Blalock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs M.L. Seits
(Address) Montour Ida

15. Filed 4-3, 1930 J.L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 19-30, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to Mar. 19, 1930
that I last saw h[illegible] alive on Mar. 19, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteria Sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montour Ida	3-22-30 19
20. Undertaker	**Address**
Case Undertaking Co.	Emmett Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70230

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44

2. FULL NAME Matthew Bilbrey

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20-1868

7. AGE Years 61 Months 6 Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10. NAME OF FATHER Thomas H. Bilbrey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Emmett Trousk
(Address) Emmett Idaho

15. Filed 4/7, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to Apr 5th, 1930
that I last saw him alive on Mar 29th, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
4/7, 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Joplin Cemetery, Eagle Idaho
Date of Burial: 4/7 1930

20. Undertaker: C D Buckmann
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70231

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 913

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob Youtsler

(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 5 1844

7. AGE Years	Months	Days	If LESS than 1 day,
85	5	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Springfield
(State or country) Illinois

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Not known

12. MAIDEN NAME OF MOTHER Carson

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Not known

14. Informant J. L. Youtsler
(Address) Boise Idaho

15. Filed 1/28, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-21-, 1930, to 1-28-, 1930
that I last saw him alive on 1-21-, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
arterio-sclerosis
several
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [redacted] M. D.
[redacted], 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	1/28 1930

20. Undertaker	Address
C. D. Buckmun	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. C. M. 1-10. RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 20232
Registered No. 131

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. R F D St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claud E. Spencer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: June (Month) 13 (Day) 1873 (Year)

7. AGE: 56 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farming.
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Elija Spencer

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Orpha Belcher

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ludah Spencer
(Address) Gooding Ida

15. Filed 4-30- 1930 J H Cromwell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

57

16. DATE OF DEATH: March (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-26- 1930 to 3-26- 1930 that I last saw h[illegible] alive on 3-28- 1930 and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Diabeetes mellitus

(Duration) 5- Yrs. mos. ds.
Contributory (Secondary) Coma
(Duration) yrs. mos. 3 ds.

(Signed) J H Cromwell M. D.
4/30 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 4-1- 1930

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 20923
Registered No. 130

1. PLACE OF DEATH

County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Rodell Ragsdale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 25 (Day) 1853 (Year)

7. AGE: 77 Yrs. 10 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ~~Ranch~~

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Hyrum Goodrich

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Henretta Sackett

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R J Ragsdale
(Address) Gooding Ida

15. Filed 4/30 1930 J A Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH: Apr. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1930 to Apr 23 1930
that I last saw her alive on Apr 23 1930
and that death occurred on the date stated above, at 9.30 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) — Yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Houston E Snyder M. D.
4-25 1930 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL 19

20. UNDERTAKER: A E Thompson — ADDRESS Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 70034
Registered No. 129

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. R.F.D. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas William Shurts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: 4 (Month) - 24 (Day) - 1930 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.
IF LESS than 1 day how many ....hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Co. Ida

10. NAME OF FATHER: George Benjamin Shurts

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Josephine Shirtz

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G. B. Shurts
(Address): Gooding, Ida

15. Filed 4-30-1930 J. H. Cromwell, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

1610

16. DATE OF DEATH: 4 (Month) - 24 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-24-1930, to 4-24-1930 that I last saw h... alive on 4-24-1930 and that death occurred on the date stated above, at 8.20 P.M.

The CAUSE OF DEATH* was as follows:
premature birth
(gestation 6½ mths)
....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.

(Signed) J H Cromwell M. D.
4/24 1930 (Address) Gooding, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 4/25 1930

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
(No. , St.)

File No. 10225
Registered No. 128

1. PLACE OF DEATH
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Elnor Perry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: April (Month) 14 (Day) 1916 (Year)

7. AGE: 13 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: schoolgirl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hamsburg, Ore.

10. NAME OF FATHER: Walter Perry

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Alice Hefner

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Walter Perry
(Address): Gooding Ida

15. Filed 4-30-1930 J. H. Cromwell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-4-1930 to 4-8-1930 that I last saw her alive on 4-8-1930, and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary): Epilepsy
(Duration) 10 yrs. mos. ds.

(Signed) J. H. Cromwell M. D.
4/9 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida — DATE OF BURIAL: 4-10-1930

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No.
File No. 10226
Registered No. 127

1. PLACE OF DEATH
County of Gooding
City of Hagerman
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Willard Ellason

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov 7 - 1900 (Month) (Day) (Year)

7. AGE: 29 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Isaac Ellason

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Arda Tilde

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E F Ellason
(Address) Hagerman

15. Filed 4 30 1930 J H Cunnall Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Gun shot wound* (suicidal)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cunnall Coroner Gooding Co Ida
19..... (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman Ida
DATE OF BURIAL: 4/8 1930

20. UNDERTAKER: Evans & Johnson
ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 2 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70242

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Wendell

(No. .... St.)

Registration District No 22

Primary Registration District No 2018

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Charles Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 10 (Day) 1865 (Year)

7. AGE: 64 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fiscal agent
(b) General nature of industry, business, or establishment in which employed (or employer): Union Central Life

9. BIRTHPLACE (State or Country): Martinsburg W. Va.

10. NAME OF FATHER: J. M. Throckmorton

11. BIRTHPLACE OF FATHER (State or Country): Martinsburg W Va

12. MAIDEN NAME OF MOTHER: Louise McDonald

13. BIRTHPLACE OF MOTHER (State or Country): Martinsburg W Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Linnie Miller
(Address) Salt Lake City Ut

15. Filed Apr 23 1930 E. L. Dimonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23d (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 23 1930, to Apr 23 1930, that I last saw him alive on Apr 23 1930, and that death occured on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

6 hours

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) High blood pressure

(Duration) ... yrs. ... mos. ... ds.

(Signed) E. L. Dimonton M. D.

4/28 1930 (Address) Wendell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utt — DATE OF BURIAL ... 191...

UNDERTAKER: Thompson Furniture Co. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of Wendell
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22-
Primary Registration District No. 2
(No. ..... St.)

File No. 70245
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene Forest

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
male	white	married

6. DATE OF BIRTH: April (Month) 15" (Day) 1863 (Year)

7. AGE: 66 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Olivier Forest

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Priscilla Desmarais

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene C. Forest
(Address) Washington, D. C.

15. Filed May 7 1930 E. L. Simonton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1929, to the time of death that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Not known - Sudden death from unknown cause. No one present at death.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Simonton M. D.
3-7 1930 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) *Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: May 4 1930

20. UNDERTAKER: David L. Herrson — ADDRESS: Jerome Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 22
Primary Registration District No. 2018
File No. 70246
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wendell (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parley J. Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1922 (Year)

7. AGE: 7 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cleveland Idu

10. NAME OF FATHER: Alfred Anderson

11. BIRTHPLACE OF FATHER (State or Country): Weston Idu

12. MAIDEN NAME OF MOTHER: Nina Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Cleveland Idu

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nina Anderson
(Address)

15. Filed Feb 8 1930 E L Dimmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1929 to Feb 7 1930
that I last saw h.. alive on Feb 6 1930,
and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Endocarditis acute with decompensation

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. L. Dimmitt M. D.
2-8 1929 (Address) Wendell Idu

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell Idu
DATE OF BURIAL: 2-9 1930

20. UNDERTAKER: None
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70251

PLACE OF DEATH
County of Grangeville
City of Idaho

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7.

100a

2. FULL NAME Gilbert Bennett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ethel Bennett

6. DATE OF BIRTH (month, day and year): Feb 12 1872

7. AGE: Years 57 | Months 11 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Butler County Kentucky

PARENTS

10. NAME OF FATHER: James Bennett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Butler County Kentucky
12. MAIDEN NAME OF MOTHER: Ann Gillstrap
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Butler County Kentucky

14. Informant: J. E. Helt
(Address): Grangeville Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 28, 1930
that I last saw him alive on Jan 28, 1930
and that death occurred, on the date stated above, at 9 25 p m.
The CAUSE OF DEATH* was as follows:
Pneumonia Bronchial
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary)
Cholecystitis (duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. D. Shinnick, M. D.
Jan 29, 1930 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Melrose Ida. | Date of Burial: 1-30 1930.

20. Undertaker: Hancock Mfg Co | Address: Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70252

PLACE OF DEATH
County of Idaho
City of West-Lake

Registration District No. 103
Primary Registration District No. 2181

Local Registrar's No. 8

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lemuel C Smith 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Lemuel C Smith

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Lemuel C Smith
(Address) West Lake Idaho

15. Filed 5/5, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 12 (Month) Wed (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
High Blood Pressure

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) W A Hancock -Coroner Idaho County M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
West Lake Ida	3-14-1930
20. Undertaker	Address
Hancock Mort Co.	Grangeville Ida.

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70253

PLACE OF DEATH
County of Grangeville
City of Idaho

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 9

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Martha Arnold

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 27, 1850

7. AGE Years 79 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Whelling West Virginia

PARENTS
10. NAME OF FATHER James W Beck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Martha Carle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant R. R. Arnold
(Address) Grangeville Idaho

15. Filed 5/5, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January, 1928, to April, 1930
that I last saw her alive on April 1, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Chronic Volvulus Heart Disease

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) J. D. Kimmick, M. D.
April 2, 1930 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 4-3-1930

20. Undertaker Hancock Mfg. Co. Address Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70254

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. Mad Geary Poolhall)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

49

2. FULL NAME Lafe R. Yates
(a) Residence. No. Grangeville Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, ~~widowed~~, or divorced HUSBAND of (or) WIFE of: Mrs Lafe Yates

6. DATE OF BIRTH (month, day and year)

7. AGE: 61 Years | Months: 0 | Days: 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retire farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS
10. NAME OF FATHER: William Yates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lenne
12. MAIDEN NAME OF MOTHER: Lieral Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Joe Yates
(Address) Grangeville Ida

15. Filed 5/5, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1927, to Apr. 29, 1930
that I last saw him alive on Apr 29, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris Major.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J S Weber M. D.
Apr 30 1930 (Address) Grangeville.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville | Date of Burial: 5/1 1930

20. Undertaker: Vassar | Address: City

RECEIVED MAY 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76255

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Lodenz Baulch

(a) Residence. No. Grangeville St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 43 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martin H Baulch

6. DATE OF BIRTH (month, day and year) July 9 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer " "

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Webster

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Parker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant M E Baulch
(Address) Grangeville

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1927, to April, 1930
that I last saw her alive on April 17 - 1930
and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary findings

(Signed) F B Chipman, M. D.
4-18-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	4-19-1930
20. Undertaker	Address
Hancock Und. Co	Grangeville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 8 1930

PLACE OF DEATH

County of Idaho

City of Grangeville

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 2181

(No. at home New Pollock)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70257

Local Registrar's No. 13

101a

2. FULL NAME Otto E. Gotzinger

(a) Residence. No. New Pollock Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, ~~widowed~~, or ~~divorced~~
HUSBAND of ~~(or) WIFE of~~ Elgie Gotzinger

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stockman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER William Gotzinger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Margaret Kelner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Elgie Gotzinger

(Address) Grangeville Idaho

15. Filed 5/5, 1930 B. Chapman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 1, 1930

that I last saw h~~im~~ alive on April 1, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Wesley F. Orrs, M. D.

4/2, 1930 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville	4/5 19
20. Undertaker	Address
Vanson Inc	City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE[redacted]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70258

County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 296

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lettie Rideout 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph R. Rideout

6. DATE OF BIRTH (month, day and year): Feb 28 - 1854

7. AGE: Years 76, Months 1, Days 14. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Calaragos Co. N. Y.

PARENTS

10. NAME OF FATHER: Nathaniel Kearsted
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Jennie Barto
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not - Oblamable

14. Informant: Ralph R Rideout
(Address): Kooskia Idaho

15. Filed April 15, 1930 J M Verberkmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to April 13, 1930
that I last saw her alive on April 12, 1930
and that death occurred, on the date stated above, at 11a m.
The CAUSE OF DEATH* was as follows:
Valvular heart disease
Arterio sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Diabetes Millitus
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M Verberkmans, M. D.
April 15, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia Cemetery
Date of Burial: April 15 1930

20. Undertaker: Geo Frenary
Address: Kooskia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70259

PLACE OF DEATH
County of Idaho
City of Nor. Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Emma Williams Parsons. 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Parsons

6. DATE OF BIRTH (month, day and year) February 1868

7. AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Jonathan Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Robert Parsons
(Address) Kiamiah Idaho.

15. Filed April 4, 1930 J M Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to April 3, 1930
that I last saw her alive on April 2, 1930
and that death occurred, on the date stated above, at 1:30 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Acute Cystitis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verberkmoes, M. D.
April 4, 1930 (Address) Kooskia-Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: First Church Cemetery (Indian) — Date of Burial: April 5 1930

20. Undertaker: Geo Trenary — Address: Kooskia-Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70260

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

78a

2. FULL NAME Theola Marie Pyne

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Angel

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2.

7. AGE Years 5 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Chas Pyne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Hester Ethel Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Chas Pyne
(Address)

15. Filed 2/14, 1930 Chas. F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to Feb 12, 1930
that I last saw her alive on Feb 12, 1930
and that death occurred, on the date stated above, at 10:00 a m.
The CAUSE OF DEATH* was as follows:

Acute endocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) John Schmerhall M.D.
Feb 13, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wendell, Idaho
Date of Burial: Feb 14 1930

20. Undertaker: Da L Henrison
Address: Jerome Idaho

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70261

PLACE OF DEATH
County of Jerome
City of Jerome R.F.D.

Registration District No. 18
Primary Registration District No.

Local Registrar's No.

(No.) 56
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Burnard Kottenbach

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None -
(b) General nature of industry, business, or establishment in which employed (or employer) None -
(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Jerome, R. 19.

PARENTS

10. NAME OF FATHER Henry Burnard Kottenbach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio Kottenbach.
12. MAIDEN NAME OF MOTHER Margent Bowerman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Toledo Ohio -

14. Informant Mr & Mrs Henry Burnard.
(Address)

15. Filed 3/13, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13, 1930, to March 13, 1930
that I last saw h~~im~~ alive on Mar. 13, 1930
and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:
Marasmus & Rickets
with influenzal infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. F. Zeller, M. D.
3/13, 1930 (Address) Jerome, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Ida.	Mar 14 1930
20. Undertaker	Address
Smith Mortuary	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70262

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48B

2. FULL NAME Wm. R. Forbes

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Kate Forbes

6. DATE OF BIRTH (month, day and year): Mar 30 30

7. AGE: Years 74, Months 9, Days 25. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: E. P. Carr
(Address): Jerome Ida

15. Filed 3/1, 1930 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to Mar 30, 1930
that I last saw him alive on Mar 23, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) John Schmersball, M. D.
Mar 31, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sweets Mortuary
Date of Burial: Apr 2 1930

20. Undertaker: Jerome, Ida.
Address: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70263

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. #18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

84

2. FULL NAME Iva Elizabeth Smith
(a) Residence. No. 4 Miles N½E Jerome St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Dr Smithall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe mal
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19/1919

7. AGE Years: 10 Months: 4 Days: 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimberly Idaho

PARENTS

10. NAME OF FATHER J. C. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plato Mo
12. MAIDEN NAME OF MOTHER Birda Acuff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tinnas Mo

14. Informant J C Smith
(Address) Jerome

15. Filed 2/12, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 10 (Day) 1930 (Year) 1-30

17. I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 10, 1930
that I last saw her alive on Feb 9, 1930
and that death occurred, on the date stated above, at 1-30 m.
The CAUSE OF DEATH* was as follows:
Pituitary tumor.
probably Congenital (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? made at Shriners Hospital Salt Lake City
(Signed) John F Schmeishall, M. D.
Feb 11, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Feb 12 1930

20. Undertaker: F C Drake
Address: Twin Falls

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70264

PLACE OF DEATH

County of Jerome

City of Jerome

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Charles Obediah Downing

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Violettie Downing

6. DATE OF BIRTH (month, day and year): Jan 13 - 1871

7. AGE: Years 59 | Months 1 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Marshaltown Iowa

PARENTS

10. NAME OF FATHER: Chas A Downing

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Ellery

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Violettie Downing

(Address): Jerome

15. Filed 2/22, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/20, 1930, to 2/21, 1930

that I last saw him alive on 2/21, 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Jerome Ida

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dan F Fried M. D.

2/22, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker: D A J Hirsons | Address: Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70265

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No. ____
(No. ____)

Local Registrar's No. 18

90

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah M. Lickley

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Lickley

6. DATE OF BIRTH (month, day and year) Mar 23 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
70		12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9. BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10. NAME OF FATHER Daniel Barber

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Harriet Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant W. J. Lickley
(Address)

15. Filed 4/5, 1930 Chas F. Zeller. M.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/3, 1930
that I last saw her alive on 4/3, 1930
and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows:
Coronary Sclerosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Cerebro Vascular Renal Disease

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) Chas F. Zeller, M. D.
____, 19____ (Address) ____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pomona Col	19
20. Undertaker	Address
W. A. Harrison	Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED APR 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70266

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 483

2. FULL NAME Harry Skimmin

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoe Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Isle of Man England

PARENTS

10. NAME OF FATHER Thomas Skimmin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Isle of Man England
12. MAIDEN NAME OF MOTHER Dant Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Isle of Man England

14. Informant Albert Skimmin
(Address) Jerome Idaho

15. Filed 3/28, 1930 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930, to Mar 28, 1930
that I last saw him alive on Mar 28, 1930
and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
with acute Dilatation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas F. Zeller, M. D.
3/29, 1930 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gooding Idaho	Mar 30 1930
20. Undertaker	Address
D A Hutchinson	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. # 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 70267

Local Registrar's No. 55

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert F. Wentland

(a) Residence. No. Hauser Lake Ida. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mellie Wentland

6. DATE OF BIRTH (month, day and year) 3-26

7. AGE	Years	Months	Days	If LESS than 1 day,
	57			hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant Dep. M. Miller

(Address)

15. Filed 4/15, 1930 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 12, 1930

that I last saw him alive on April 12, 1930

and that death occurred, on the date stated above, at 2.45 A. m.

The CAUSE OF DEATH* was as follows:

188 Accidental traumatism
Automobille accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lung hemorrhage, 17 broken ribs. (duration) yrs. 10 mos. hrs.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical signs

(Signed) E. L. Sloan M. D.

April 14, 1930 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Evergreen Cem. Rathdrum — Date of Burial: 4-16 1930

20. Undertaker: Cassedy Funeral Home — Address: C'dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70268

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 56

1000

PLACE OF DEATH

County of Kootenai
City of Coeur d Alene
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Charlotte Dennis

(a) Residence. No. 518 - 7th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1914 - 8 - 16

7. AGE	Years	Months	Days	If LESS than 1 day,
	15	7	25	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sask. Canada

PARENTS

10. NAME OF FATHER Frank Dennis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Hulda Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Frank Dennis
(Address)

15. Filed 4/15, 1930 H. J. Sturgeon. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 10, 1930
that I last saw h.er alive on April 10, 1930
and that death occurred, on the date stated above, at 6 20 P.M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) ..... yrs. ..... mos. 1½ ds.
CONTRIBUTORY (Secondary) Hypothyroidism, Epilepsy
(duration) 9 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of /
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Harold I. Anderson, M. D.
April 11, 1930 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdA	4-12 1930
20. Undertaker	Address
Cassedy Funeral Home	CdA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70269

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 57

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

2. FULL NAME Annie Ed. Williams

(a) Residence. No. 11th + Maple St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jabez Williams

6. DATE OF BIRTH (month, day and year) 857-8-3

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS

10. NAME OF FATHER Wm Pett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Hooper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis.

14. Informant Mary U. Whitla
(Address)

15. Filed 4/15/, 1930 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to Apr 13, 1930
that I last saw h[e] alive on Apr. 11, 1930
and that death occurred, on the date stated above, at 9:50 a.m.
The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) Last 3 months mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. D. Sturgess, M. D.
April 15, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D'Alene	4-15 1930
20. Undertaker	Address
Cassedy Funeral Home	C D'Alene.

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70270

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 58
(No.) 748
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Mitchell

(a) Residence. No. 818 Montana St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Louis Mitchell

6. DATE OF BIRTH (month, day and year) 1861-6-5

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	10	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Pape
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Elizabeth —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Katherine Mitchell
(Address)

15. Filed 4/15, 1930 H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~March~~ Apr. ~~25~~ 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to Apr. 12, 1930
that I last saw her alive on April 11 1930
and that death occurred, on the date stated above, at 9:30 a. m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Arteria sclerosis - hypertension
(duration) Not yrs. One mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of No
Was there an autopsy?
What test confirmed diagnosis? J. C. Always
(Signed) , M. D.
April 14 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdA	4-15-1930
20. Undertaker	Address
Cassedy Funeral Home	CdA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70271

Registration District No. 20
Primary Registration District No. 1050
Local Registrar's No. 59

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No.) 167

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Lurene Symons.

(a) Residence. No. Madena St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 8-13

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	1	4	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene. Ida
(State or country)

PARENTS

10. NAME OF FATHER Spencer Symons.

11. BIRTHPLACE OF FATHER (city or town) Hueston. Ida.
(State or Country)

12. MAIDEN NAME OF MOTHER Zelda Babbit

13. BIRTHPLACE OF MOTHER (city or town) Coeur d'Alene Ida.
(State or Country)

14. Informant Mrs. Spencer Symons
(Address)

15. Filed 4/21, 1930 H. J. Sturges MD.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Sudden death occurred before my arrival
Probable Thymus
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. O. Dwyer M. D.
4/19, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD Alene	4-19 1930
20. Undertaker: Cassedy Funeral Home	Address: CD Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70272

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 60

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

(No.) 740
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Augustus C. Brout

(a) Residence. No. 1001 Front St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Brout

6. DATE OF BIRTH (month, day and year) Jan 27 - 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	3	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber cruiser
(c) Name of employer J Ferried Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Julius Brout
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Clara Brout
(Address) Coeur d'Alene Idaho

15. Filed 4/29, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1925, to Apr. 20, 1930
that I last saw him alive on Apr. 20, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis and
nephritis (duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) John Elwood, M. D.
Apr. 21, 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane Wn.	

20. Undertaker R. B. Mooney Address Coeur d'Alene

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70273

PLACE OF DEATH

County of Kootenai

City of [redacted]

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 61

(No. [redacted])

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Duncan

(a) Residence. No. Hayden Lake St.

(Usual place of abode)

Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 15 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	0	5	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant William Buckler

(Address) Hayden Lake Ida.

15. Filed 4/29, 1930 W. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 20, 1930

that I last saw h[redacted] alive on April 19, 1930

and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.

April 21, 1930 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Bur Cremation	4/22 1930
20. Undertaker	Address
P. D. Mooney	Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20274

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 30
Primary Registration District No. 1060
(No. 1010)
Local Registrar's No. 62
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia L. Montague

(a) Residence. No. 4 Miles West C. D' A. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 4, 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	6	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Albert Southworth

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Paul A. Montague,
(Address) Post Falls, Ida.

15. Filed 4/29/, 1930. H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-19-, 1930, to April 15, 1930
that I last saw her alive on April 15, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Paralysis Agitans 5-
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Teed, M. D.
4-23, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Forest Cemetery	4/24/30
20. Undertaker	Address
T. B. Mooney	Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Hooley. Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1030.

(No. ..... St.)

File No. 20275

Registered No. 63

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha M. Riley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 11th 1880.
(Month) (Day) (Year)

7. AGE: 49 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: General House-Work.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: John Anderson.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Riley

(Address) Hooley. Idaho.

15. Filed May 1st 1930

H. J. Sturgeon M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH: April 26th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15th 1929, to April 26th 1930.

that I last saw her alive on April 26. 1930;

and that death occurred on the date stated above, at 11:0 A.M.

The CAUSE OF DEATH* was as follows:

Uterine Cancer.

(Duration) 4 Yrs. — mos. — ds.

Contributory (Secondary): General Debility

(Duration) 2 yrs. — mos. — ds.

(Signed) J. F. Herrington M. D.

19..... (Address) Hooley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Rockford. Wn. DATE OF BURIAL: Apr. 28 1930

20. UNDERTAKER: [illegible] ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70276

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 4
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Nicholas Romano 90

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Mary Romano

6. DATE OF BIRTH (month, day and year) 1880 - 2 - 5

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	2	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Brugnatura
(State or country) Province of Catanzaro. Italy

PARENTS

10. NAME OF FATHER Sandy Romano

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy

12. MAIDEN NAME OF MOTHER Concetta —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Brugnatura Italy

14. Informant Tony Romano
(Address) Harrison Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to April 4, 1930
that I last saw h. im alive on April 10, 1930
and that death occurred, on the date stated above, at 5:45 P.m.
The CAUSE OF DEATH* was as follows:

Failure of compensation of heart.
(duration) — yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Organic valvular
Heart lesions (duration) 2 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) H. W. Shryock M. D.
April 15, 1930 (Address) Harrison, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison. Ida.	4-16 1930
20. Undertaker	Address
Cassedy Funeral Home	Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70277

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 5

(No.) 112
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Warren Westley Doty

(a) Residence. No. / St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Ann Doty

6. DATE OF BIRTH (month, day and year) 1849 - 5 - 22

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	11	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Ira Doty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dept. Know.
12. MAIDEN NAME OF MOTHER Solina Root-
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont. Know.

14. Informant Frederick Alden Doty.
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30, 1930 to Mar. 27, 1930
that I last saw him alive on April 24, 1930
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Subacute gastritis (Flu type)
Senility
(duration) yrs. 1 mos. + ds.
CONTRIBUTORY (Secondary) Senility
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) H. W. Shryock, M. D.
April 29, 1930 (Address) Harrison.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida.	4-30 1930
20. Undertaker	Address
Cassedy Funeral Hm	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene,

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70278

Local Registrar's No. 53

48 B

2. FULL NAME Karl W. Bush

(a) Residence. No. Dalton Gardens St. Almira, Wn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 4, 1840

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	3	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown Bush

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Joseph Bush

(Address) Almira, Wash.

15. Filed 4/9, 1930 W. J. Burges. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 7, 1930

that I last saw him alive on April 7, 1930

and that death occurred, on the date stated above, at 345 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. E. Brown M. D.

April 7, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Almira Wn.	4-10 1930

20. Undertaker T. B. Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70279

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 54

129

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Frederic

(a) Residence No. 114 - Indiana St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie Frederic

6. DATE OF BIRTH (month, day and year) 1846 - 11 - 11

7. AGE	Years	Months	Days	If LESS than 1 day,
	83	4	27	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cincinnati Ohio.

PARENTS

10. NAME OF FATHER Adam Frederic
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Catherine Humbach
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. B. Frederic
(Address)

15. Filed April 10, 1930 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18, to Apr. 7, 1930
that I last saw him alive on Apr. 6, 1930
and that death occurred, on the date stated above, at 1 a. m.
The CAUSE OF DEATH* was as follows:
Interstitial
Chronic Nephritis - Arteriosclerosis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. Adams, M. D.
Apr. 8, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. CDAlene	4-10 1930
20. Undertaker	Address
Cassedy Funeral Home	CDAlene

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70280

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 6011
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

164

2. FULL NAME ROSEMOND M. WHITE

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Hawley White

6. DATE OF BIRTH (month, day and year) Aug. 27, 1834

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
95	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Wixon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant F. C. WHITE
(Address) Moscow Ida.

15. Filed May 8, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 15, 1930, that I last saw h[illegible] alive on April 18, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was ~~as follows~~:
Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. C. Glass, M. D.
April 17, 1930 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	4/20 1930
20. Undertaker	Address
H. R. Short	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70281

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 16
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

12

2. FULL NAME John A. Mortenson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Mortenson

6. DATE OF BIRTH (month, day and year) July 23, 1863

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Bank Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer First Trust & Saving

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER John Mortenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs. Ida Mortenson
(Address) Moscow, Ida.

15. Filed 5/8, 1930. John Erickson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to April 9, 1930
that I last saw him alive on April 9, 1930
and that death occurred, on the date stated above, at 12:25 A. m.
The CAUSE OF DEATH* was as follows:

Acute nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. E. Gritman, M. D.
4/11, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	4/13/30 19

20. Undertaker	Address
F. R. Short	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

PLACE OF DEATH

County of Latah

City of Moscow

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 10 11

(No. 315 Second St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70282

Local Registrar's No. 15

131

2. FULL NAME Amy M. Carpenter

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C.C. Carpenter

6. DATE OF BIRTH (month, day and year) Nov. 3, 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	5	7	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Almeron Randall

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Wright

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Mrs. Carpenter

(Address) Moscow Idaho

15. Filed 5/8, 1930 Clara Eastwood Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1929, to April 9, 1930

that I last saw h 24 alive on April 9, 1930

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. L. Gritman, M. D.

4/11, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	4/11/30 19

20. Undertaker	Address
H. R. Short	Moscow

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76283

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

187

2. FULL NAME Cuthbert Hickman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6, 1930

7. AGE: Years | Months | Days: 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Moscow, Idaho

PARENTS
10. NAME OF FATHER: Cuthbert W/ Hickman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Tess Keane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ida.

14. Informant: C.W. Hickman
(Address) Moscow, Idaho

15. Filed May 8, 1930 Harry Einhouse Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. 9, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 9, 1930
that I last saw him alive on April 9, 1930
and that death occurred, on the date stated above, at 12:15 P m.
The CAUSE OF DEATH* was as follows:
Growth obstructing respiratory passage.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
4/10, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Genesee
Date of Burial: 4/10/30 19

20. Undertaker: F. R. Short
Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70284

Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 13

PLACE OF DEATH
County of Latah
City of Moscow
(No.) 204
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Perry Black

(a) Residence. No. St. Garfield, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Frances Black

6. DATE OF BIRTH (month, day and year) Oct. 9, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Millerstown Pa.

PARENTS

10. NAME OF FATHER Johnathan Black
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Hennretta Kramer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant John Black
(Address) Moscow, Ida.

15. Filed 5/8/30, 19 Harry Einhouse Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4:30p m.

The CAUSE OF DEATH* was as follows:
Died while sitting in pool hall.
Probably: acute myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. R. Short Coroner, M. D.
4/7, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal	Date of Burial
Garfield Wash	4/8 1930
20. Undertaker	**Address**
F. R. Short	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 17 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20085

County of .....
City of .....
Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

(No. ..... St. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John E Lind

(a) Residence. No. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6. DATE OF BIRTH (month, day and year): Nov 19 1856

7. AGE — Years: 73 | Months: 4 | Days: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: .....
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: April Lind
(Address): Troy Idaho

15. Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 7, 1930, that I last saw him alive on April 7, 1930 and that death occurred, on the date stated above, at 1:50 m.

The CAUSE OF DEATH* was as follows:

Double pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Chas L. Gilman M. D.
4/7, 1930 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Removed to Troy Ida.	
20. Undertaker: John J Prichard	Address: Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70286

PLACE OF DEATH

County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 10 11

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME RITA MARIE SAUNDERS

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 5, 19 19

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	4	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Chicago
(State or country) Ill.

PARENTS

10. NAME OF FATHER Robert Saunders
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Anna Schultz
13. BIRTHPLACE OF MOTHER (city or town) Chicago
(State or Country) Ill.

14. Informant Henry Schultz
(Address) Moscow Ida.

15. Filed 3/27, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1929, to March 26, 1930, that I last saw her alive on March 22, 1930 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Acute endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute myocarditis.

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.

(Signed) A. Armstrong, M. D.
3/27, 1930 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Removal to Chicago	
20. Undertaker F. R. Short	Address Moscow

RECEIVED APR 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20287

PLACE OF DEATH

County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
(No.)
Local Registrar's No. 16

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

1000

2. FULL NAME Arthur Gloyd Barton

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 7, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moscow Idaho

PARENTS
10 NAME OF FATHER Edward L. Barton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.
12 MAIDEN NAME OF MOTHER Josephine Hammond
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Edward Barton
(Address) Moscow, Ida.

15 Filed 4/14, 1930 Stacy Eichwald Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 3/17/30, 19, to 3/29/30, 19, that I last saw h~~er~~is alive on 3/23/30, 19, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia.
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Ileo colitis acute.
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) M. D.
3/24, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	3/24/30 19
20. Undertaker H. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFAILING INK—THIS IS A PERMANENT RECORD.

RECEIVED APR 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70288

PLACE OF DEATH
County of Latah
City of Juliaetta
Registration District No. 63
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME James Marion Lafon

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Lafon

6. DATE OF BIRTH (month, day and year): April 16 1860

7. AGE: Years 69 | Months 11 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Franklin, Mo

PARENTS
10. NAME OF FATHER: John Lafon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Catherine Whitmore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Mrs Addie Lafon
(Address): Juliaetta or Rural Juliaetta

15. Filed Mar 21, 1930. B. F. Neabit, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mar 21, 1930, that I last saw him alive on Mar 2, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. H. Fifield, M. D.
Mar. 21, 1930 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ivy Ridge — Date of Burial: Mar 23rd 1930

20. Undertaker: John J. Packard — Address: Troy Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RF D APR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70289

PLACE OF DEATH

County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Hariett Jenesa Benson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George L Benson

6. DATE OF BIRTH (month, day and year) April 24 — 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	10	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER I D Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Hannah M. Kinyon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Geo. L Benson
(Address) Palouse Wash.

15. Filed March 23, 1930 J W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1930, to March 21, 1930
that I last saw her alive on March 21, 19...
and that death occurred, on the date stated above, at 6 45 A m.
The CAUSE OF DEATH* was as follows:

Cancer of breast.

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1927
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J.W. Thompson. M. D.
March 23, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greene Cem	March 24 1930

20. Undertaker J M Irwin Address Palouse Wash.

FORM V. S. No. 5.25 M. 1-19. APR 24 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 70290
Registered No.

1. PLACE OF DEATH
County of LATAH
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME HENRY COLBY MOORE
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: SINGLE (Write the word.)

6. DATE OF BIRTH: APRIL (Month) 3 (Day) 1930 (Year)

7. AGE: Yrs. Mos. 4 ds.
IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): LATAH CO - IDAHO

10. NAME OF FATHER: HENRY FLOYD MOORE

11. BIRTHPLACE OF FATHER (State or Country): OKLAHOMA

12. MAIDEN NAME OF MOTHER: ESTHER ALBERTA LONG

13. BIRTHPLACE OF MOTHER (State or Country): CANADA

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Colby Moore
(Address) Princeton - Idaho

15.
Filed April 7th 1930 W. J. Thompson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

1590

16. DATE OF DEATH: APRIL (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from APRIL 3 1930, to APRIL 7 1930
that I last saw him alive on APRIL 5 1930,
and that death occurred on the date stated above, at 6:30 AM.

The CAUSE OF DEATH* was as follows:
CONGENITAL CARDIAC
INSUFFICIENCY

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Hyden Hancher M. D.
4-7 1930 (Address) Potlatch - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery
DATE OF BURIAL: April 7th 1930

20. UNDERTAKER: Parents
ADDRESS: Princeton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70291

PLACE OF DEATH

County of Latah
City of Potlatch

Registration District No. 66
Primary Registration District No. 2148

Local Registrar's No.

(No.) 170
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Wesley Arbuckle

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 2 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	7	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Water tman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Potlatch Lumber Co

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER H. C. Arbuckle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ills
12. MAIDEN NAME OF MOTHER Sarah Sanfield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs C. M. Arbuckle
(Address) Potlatch Ida

15. Filed April 4 1930 J. M. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Suicidal
Self inflected revolver wound in heart.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ill. Health
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Farmington Wash	April 6 1930

20. Undertaker Address
E. M. Irwin Colfax Wash.

FORM S. No. 5-25 M. 1-16-13

RECEIVED APR 17 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No.
(No. ..... St.)

File No. 70293
Registered No. 156

1. PLACE OF DEATH.
County of Nezperce
City of Village
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenard Leon Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. Mar (Month) 6 (Day) 1930 (Year)

7. AGE: 74 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Cook in Restaurant

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Miller

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER X

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie L. Miller
(Address) Nezperce Idaho

15. Filed April 14 1930 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH
Feb 9 (Month) Mar 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1930, to March 6 1930, that I last saw him alive on March 6 1930, and that death occured on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:
Tachycardia of Heart
(Duration) Yrs. 1 mos. 4 ds.
Contributory (Secondary) Injury To Spine
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E T Taylor M. D.
3-6 1930 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. ~~PLACE OF BURIAL OR~~ REMOVAL: Lewiston Idaho
DATE OF BURIAL: Mar 9 1930

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Idaho

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 17 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Nyperceddale village

Registration District No. 47

Primary Registration District No.

(No. ..... St.)

File No. 70294

Registered No. 149

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fannie Martha Ann Hunsucker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write Married.)

6. DATE OF BIRTH. October (Month) 12 (Day) 1856 (Year)

7. AGE 73 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Conover N. C.

10. NAME OF FATHER Elijah Cline

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Echard

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W T Sharp
(Address) Steptoe Wash

15. Filed Feb 2 1930 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Jan (Month) 7 (Day) 2 20 a.m. 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1930, to Jan 3 1930, that I last saw her alive on Jan 3 1930, and that death occured on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Arteriosclerosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B. Chipman M. D.

1/13/1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nyperce Cemetery

DATE OF BURIAL: Jan 9 1930

20. UNDERTAKER: Albert Huff

ADDRESS: Nyperceddale

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. RECEIVED MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lewis

City of Reubens

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 50

Primary Registration District No. 2129

(No. ..... St.)

File No. 70295

Registered No. 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Wm Litchfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March (Month) 11th (Day) 1862 (Year)

7. AGE: 68 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich ?

10. NAME OF FATHER: John Barnhart

11. BIRTHPLACE OF FATHER (State or Country): USA

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): USA

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Weller

(Address) Winchester Ida

15. Filed Apl 26 1930 R E Dewey Local Registrar

MEDICAL CERTIFICATE OF DEATH

204

16. DATE OF DEATH: Apr (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from saw 19 to Dead in bed 19

that I last saw h..... alive on ..... 19....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Sudden Death, Valvular Heart Disease according to her Physician Dr Watts Gifford Ida

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) K M Laughlin M. D.

Apr 23 1930 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Reubens Cemetery

DATE OF BURIAL: 4/24 1930

20. UNDERTAKER: Harry Weller

ADDRESS: Winchester

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70296

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
(No. Columbia Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

2. FULL NAME Hisomasa Katayama

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Kishinpo Katayama

6. DATE OF BIRTH (month, day and year) Sept 28 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Waiter (Restaurant)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant Chas Mori
(Address)

15. Filed May 10, 1930 J. L. Freeze Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 8, 1930
that I last saw him alive on May 7, 1930
and that death occurred, on the date stated above, at 9:00 P. m.
The CAUSE OF DEATH*. was as follows:
Coronary Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) T. E. Hurst, M. D.
5/9, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland Ore / Shoshone Idaho — Date of Burial: May 11 1930

20. Undertaker: C E Hickok — Address: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70297

PLACE OF DEATH

County of Lincoln

City of Richfield

Registration District No. 16

Primary Registration District No. 2016

Local Registrar's No. 9

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME ~~Lewis~~ Lewis C Eastwood

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 14 1866

7. AGE: Years 64 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: Frances M Eastwood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Josephine Mourning

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ills

14. Informant: Mrs Hugh Fenton
(Address)

15. Filed May 3, 1930 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to April 30, 1930

that I last saw him alive on April 30, 1930

and that death occurred, on the date stated above, at 11.30 P.m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Asthma

..... (duration) 30 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tiny Exam

(Signed) F. E. Baruto, M. D.

5/2, 1930 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harley Idaho | Date of Burial: May 4 1930

20. Undertaker: C E Hickok | Address: Shoshone

RECEIVED MAY 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70298

PLACE OF DEATH

County of Lincoln

City of Shoshone

Registration District No. 10

Primary Registration District No. 1016

Local Registrar's No. 8

(No. Dill Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME Gottfried Gehrig

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 9, 1867

7. AGE: Years 63, Months 1, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Clarence F. Gehrig
(Address): Shoshone Ida

15. Filed April 14, 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to April 12, 1930 that I last saw him alive on April 12, 1930 and that death occurred, on the date stated above, at 4 30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Flu,

(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? Home on ranch

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Death

(Signed) [signature] M. D.

....., 19.... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone

Date of Burial: April 14 1930

20. Undertaker: C. E. Hickok

Address: Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76299

PLACE OF DEATH

County of Lincoln
City of Shoshone
Registration District No. 1 E
Primary Registration District No. 101 E
Local Registrar's No. 7
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. **FULL NAME** Nancy M Kenaston

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Harvey A Kenaston

6. DATE OF BIRTH (month, day and year) Jan 7 1863

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	3	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Martin Potter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Mary Shaw

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Anna L McVay
(Address) .....

15. Filed April 12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) — 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 11, 1930
that I last saw her alive on April 11, 1930
and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
.....
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) W. T. Baugh M. D.
4-12-, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone	April 13 1930
20. Undertaker	Address
C E Hickox	Shoshone

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70300

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 73
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4-2

112

2. FULL NAME Betty June Stoddard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Thomas S. Stoddard

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 2 | Months 9 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rexburg Idaho

PARENTS

10. NAME OF FATHER: Thomas S. Stoddard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Beaver Canyon Idaho
12. MAIDEN NAME OF MOTHER: Mae Beatty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Thomas S. Stoddard
(Address)

15. Filed Mar 15, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 12, 1930, to Mch 13, 1930
that I last saw her alive on Mch 13, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Malnutrition
..... (duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary): Anthropoid Meningitis
..... (duration) ..... yrs. ..... mos. 30 ds.

18. Where was disease contracted if not at place of death? Rexburg, Idaho
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burton Cemetery | Date of Burial: Mar 17 1930

20. Undertaker: [signature] | Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

MAY 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 70304

Local Registrar's No.

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: April 21 (Month) (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. 2

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF Father: Mark H. Lutz

11. BIRTHPLACE OF FATHER (State or Country): Rexburg Ida

12. MAIDEN NAME OF MOTHER: Sarah L. Simpson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mark H. Lutz

(Address) Rexburg Ida

15. Filed 4/21 1930 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH 161a

16. DATE OF DEATH: April (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1930, to April 21 1930, that I last saw her alive on April 21 1930, and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Premature.
Icterus Neonatorum

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Toxemia due to macerated foetus (Twin)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Rigby M. D.

4/21 1930 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER: A. B. Eckersell | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. [illegible] M. 1-19. MAY 16 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 278
(No. ..... St.)

File No. 70305
Registered No. 21

1. PLACE OF DEATH
County of Madison
City of Rexburg,
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Arthur Ray,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: March 19th (Month) (Day) 1930 (Year)

7. AGE: Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) Infant

9. BIRTHPLACE (State or Country) Rexburg Idaho

10. NAME OF FATHER: J Alvin Ray

11. BIRTHPLACE OF FATHER (State or Country): South Weber Utah

12. MAIDEN NAME OF MOTHER: Margaret Midelton

13. BIRTHPLACE OF MOTHER (State or Country): Rexburg Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Alvin Ray
(Address) Rexburg Idaho

15. Filed May 8 1930 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

107

16. DATE OF DEATH: May 7th (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1930, to May 7 1930
that I last saw him alive on May 6 1930,
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Meningitis
Lung Abscess (Left Lung)
with Pneumothorax +
Empyema.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Abscess Rt. Parietal Lobe
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H B Rigby M. D.
May 7 1930 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Cem. — DATE OF BURIAL: May 8 1930

20. UNDERTAKER: Wm. H. Keller — ADDRESS: Rexburg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70906

PLACE OF DEATH
County of Madison
City of Thornton

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 22

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1-93

2. FULL NAME Infant Son Of Clarence Webb.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 30 1930

7. AGE Years	Months	Days	If LESS than 1 day, 36 hrs. or min.
X	X	X	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Thornton Ida

PARENTS

10. NAME OF FATHER Clarence Webb

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lehi Utah

12. MAIDEN NAME OF MOTHER Alta Simmons

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Clarence R. Webb
(Address) Thornton Idaho

15. Filed 5/9, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
4-30, 1930, to 5-2, 1930
that I last saw him alive on 5-2, 1930
and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:
Congenital Heart Lesion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. Sutherland, M. D.
5-8, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burton Ida	May 3 1930
20. Undertaker	Address
Evans & Teller	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70307

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 7069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

111B

2. FULL NAME Andrew Crawford Jenkins

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 1 - 1897

7. AGE

Years	Months	Days	If LESS than 1 day,
33	1	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Portage Utah

PARENTS

10. NAME OF FATHER: William T. Jenkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Council Bluffs Iowa
12. MAIDEN NAME OF MOTHER: Margaret J. Glover
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Farmington Utah

14. Informant: J. Merlin Jenkins
(Address) Malad Ida

15. Filed 4/31, 1930 J. M. Kerns. Registrar
By Carmen Davis.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 4, 1930
that I last saw him alive on April 4, 1930
and that death occurred, on the date stated above, at 9.45 P m.
The CAUSE OF DEATH* was as follows:
Perforated gastric ulcer near duodenal opening of stomach.
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic gastric ulcer
..... (duration) 6 yrs. 21 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? Post mortem findings.
(Signed) V. P. Garst, M. D.
April 5, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John Ida
Date of Burial: Apr 7 1930

20. Undertaker: J. Guy Benson
Address: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70308

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

164

2. FULL NAME Sarah Jane Kinnamon

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 24-1844

7. AGE Years 85 Months 5 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nauvoo Ill.

PARENTS
10. NAME OF FATHER Richard Kinnamon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Margaret Fitz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Lettie Meredith
(Address) Malad Idaho

15. Filed 4/31, 1930 J. M. Kerns Registrar
By Carmen Davis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1930 to April 21, 1930
that I last saw her alive on April 21, 1930
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
General debility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. Malay M.D.
4/23, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Utah
Date of Burial Apr. 25 1930

20. Undertaker J. Guy Benson
Address Malad Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70309

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

101a

2. FULL NAME Robert Ranae Thompson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 10. 1928

7. AGE Years 1 Months 7 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad Ida.

PARENTS

10. NAME OF FATHER Robert Evans Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pleasantview Ida.
12. MAIDEN NAME OF MOTHER Ethel Daniels
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Malad Ida.

14. Informant Robert E. Thomson.
(Address) Malad Ida

15. Filed 4/31, 1930 J. M. Kerns, Registrar
By Carmen Davis.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 22. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 22, 1930
that I last saw him alive on April 22, 1930
and that death occurred, on the date stated above, at 1 20 a m.
The CAUSE OF DEATH* was as follows:
Tabar pneumonia
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Hooping cough
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) O. H. Mabey, M. D.
4/22, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial Apr 24 1930

20. Undertaker J. Guy Benson
Address Malad Ida

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70310

PLACE OF DEATH

County of Power — Registration District No. 25

City of American Falls, Idaho — Primary Registration District No. 2072

Local Registrar's No. 8

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

1002

2. FULL NAME Frank S. Gall

(a) Residence. No. 25 miles south, Am Falls, St.

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rosina Gall

6 DATE OF BIRTH (month, day and year) Feb 1849

7 AGE — Years: 81 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Gall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Gall

(Address): Rockland, Idaho

15 Filed April 30, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to April 23, 1930,
that I last saw him alive on April 23, 1930,
and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/34/30 19... (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rockland — Date of Burial: 4-27 1930

20. Undertaker: A.W.Davis — Address: American Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70311

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Power

City of Rockland

Registration District No.

Primary Registration District No.

(No.)

Local Registrar's No. 7

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

131

2. FULL NAME John Eleason

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs John Eleason

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 76 Months 4 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER: Elias Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Eliza Mary Otterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Edgar Eliason
(Address)

15 Filed April 22, 1930 Genevieve Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 21 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Apr 21, 1930, that I last saw h alive on April 20th, 1930, and that death occurred, on the date stated above, at 6:15 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P G Logan, M. D.

4-22, 1930 (Address) American Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rockland

Date of Burial: Apr. 23 1930

20. Undertaker: Kamely

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70312

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

1016

2. FULL NAME Charles A. Biotti

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lauretta Smith

6. DATE OF BIRTH (month, day and year) Aug 16, 1897

7. AGE	Years	Months	Days	If LESS than 1 day,
	32	7	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg, Ida.

PARENTS

10. NAME OF FATHER John Biotti
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Rachel Vergobbi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Henry C. Britts
(Address) 107 E. Mission Kellogg, Idaho

15. Filed Apr. 30, 1930 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to March 26, 1930
that I last saw him alive on March 26, 1930
and that death occurred, on the date stated above, at 11:15 a.m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Chronic nephritis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Geo. H. Kennett, M. D.
April 15, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Mch 29 193
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

April 5, 1935

To: Bureau of Vital Statistics,
Department of Public Welfare,
State of Idaho.
Boise, Idaho.

AFFIDAVIT

I certify that line 5a of Certificate of Death of Charles A. Biotti, your file #70312, left blank, should properly be filled in with the following "Lauretta Smith".

I further certify that Lauretta Smith is known to me as the divorced wife of Charles A. Biotti.

Emma Lavigne
Emma Lavigne

Subscribed and sworn to before me this 5th day of April 1935 at Kellogg, Idaho.

[signature] Notary Public,

Residing at Kellogg, Idaho.

My Commission Expires April 30, 193?
Residence - Kellogg, Idaho

RECEIVED APR 8 1985

April 5, 1935

To: Bureau of Vital Statistics,
Department of Public Welfare,
State of Idaho.
Boise, Idaho.

AFFIDAVIT

I certify that line 5a of Certificate of Death of Charles A. Biotti, your file #70312, left blank, should properly be filled in with the following -

"Lauretta Smith"

I further certify that Lauretta Smith is known to me as the divorced wife of Charles A. Biotti.

Further, I certify that I was the attending nurse at the time of death of Charles A. Biotti.

Freda Lampman

Subscribed and sworn to before me this 5th day of April 1935 at Kellogg, Idaho.

Vernon Reed Notary Public,

Residing at Kellogg, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70313

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

117

2. FULL NAME Allison Gale Sheldon

(a) Residence. No. 420 Main St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 13 - 1911

7. AGE Years 18 Months 3 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Plankinton S. Dak.

PARENTS

10. NAME OF FATHER Charles E. Sheldon

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Beaman, Iowa.

12. MAIDEN NAME OF MOTHER Flora V. Robertson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Champaign Ill.

14. Informant Charles E. Sheldon
(Address) 420 Main Kellogg Ida

15. Filed Apr 1, 1930 S. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) ~~29~~ 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28th, 1930, to March 30, 1930, that I last saw him alive on March 30, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Advanced Pulmonary T.B.

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of March 28th 1930
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W. C. Lindsay, M. D.
3/31, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Greenwood Ida
Date of Burial Apr. 1 1930

20. Undertaker M. C. Thornhill
Address Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70314

PLACE OF DEATH
County of Shoshone
City of Burke

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

205-B

2. FULL NAME Premature Fetus

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years about | Months: 4 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) No information

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Bever
(Address) Wallace

15. Filed 3/29, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Not known 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Found dead in flume at Burke Ida
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Premature 4 mo fetus
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. C. Mowrer Coroner M.D.
3/27, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Idaho | Date of Burial: March 31 1930

20. Undertaker: J. A. Bever Ward Und Co | Address: Wallace Ida

FORM V. S. No. 3-25 M. 3-14-30 RECEIVED APR 18 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 70315

Registered No. 31

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dave Irvine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. 2 (Month) 20 (Day) 1867 (Year)

7. AGE 63 Yrs. 1 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burlington Mo.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) John Irvine N.Y.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. M. Rogers

(Address) Shoshone County Infirmary

15. Filed Mar 28 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 25 (Day) 1930 (Year) 105

17. I HEREBY CERTIFY, That I attended deceased from 10-19- 1926, to 3-25- 1930, that I last saw him alive on 3-24- 1930, and that death occured on the date stated above, at 7.45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

3/26 1930 (Signed) James R Brown M. D.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. 5 mos. 6 days. In the State 37 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace

19. PLACE OF BURIAL OR REMOVAL Kellogg Ida

DATE OF BURIAL Mar 28 1930

20. UNDERTAKER R. L. Stout

ADDRESS Kellogg Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70316

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

101a

2. FULL NAME Clifford Maxwell Buchanan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 20, 1913

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
16	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Walter Buchanan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Lucy Justus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Walter Buchanan
(Address) Page, Idaho

15. Filed Mar 11, 1930 L. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17 a, 1930, to Mch 19, 1930
that I last saw him alive on Mch 19, 1930
and that death occurred, on the date stated above, at 8:40 a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Kellogg Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physicians
(Signed) Max T. Smith M. D.
3/20/30, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho
Date of Burial: Mch 21 1930

20. Undertaker: M. C. Thornhill
Address: Kellogg, Ida

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76317

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 7011
Local Registrar's No. 29

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

99 R

2. FULL NAME James Leamon

(a) Residence Shoshone Co. Infirmary St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Prospector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant LeRoy Massey
(Address) Wallace Ida

15. Filed Mar 14, 1930. L. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Feby, 1930, to 3/12/30, 19
that I last saw him alive on 3/12/30, 19
and that death occurred, on the date stated above, at 12.45 p m.

The CAUSE OF DEATH* was as follows:

Chr. Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

3/21/30, 19 (Signed) James L Bean, M. D.
(Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan Ida	Mar 14 1930
20. Undertaker	Address
P. L. Hunt	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED APR 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70318

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

88 B

2. FULL NAME Margaret Brown
(a) Residence. No. 112 - 3rd St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed
6. DATE OF BIRTH (month, day and year) Nov 17 - 1845
7. AGE 84 Years | Months 4 | Days 0 | If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mr Geo Brown
(Address) Wallace, Idaho.
15. Filed Mar 20, 1930 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 17 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ___, 1928, to Mch 17, 1930
that I last saw her alive on ___, 19__
and that death occurred, on the date stated above, at 9:30 p.m.
The CAUSE OF DEATH was as follows: Myocarditis Chr
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) Several yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Morrey, M. D.
3/18, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Libby Mont. | Date of Burial Shipped March 20 1930
20. Undertaker J. A. Bever Ward Und Co. | Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70320

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

126

2. FULL NAME Elmer Edwin Harrison Bergey
(a) Residence. No. Gem Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 16 - 1927
7. AGE Years 2 Months 8 Days 25 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Spokane Wash.

PARENTS
10. NAME OF FATHER Elmer Bergey.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Harriet Ferguson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc

14. Informant Elmer Bergey.
(Address) Gem, Idaho.
15. Filed Mar 15, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 7, 1930 to Mar 11, 1930
that I last saw him live on Mar 11, 1930
and that death occurred, on the date stated above, at 11:30 P. m.
The CAUSE OF DEATH* was as follows: Peritonitis General
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) several ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Drs Mowery, M. D.
3/12, 1930 (Address) Wallace, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho. Date of Burial: March 15 1930
20. Undertaker: J. A. Bever Ward Und. Co. Address: Wallace, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

[illegible]—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- [illegible] is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70321

PLACE OF DEATH
County of Shoshone
City of ~~Kellogg~~ Wallace

Registration District No. 70
Primary Registration District No. 10 11
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

100a

2. FULL NAME Wallace Massie Matson

(a) Residence. No. 108 McKinley ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 6-1929

7. AGE Years | Months 9 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg Ida
(State or country)

PARENTS

10. NAME OF FATHER Wallace Joe Matson
11. BIRTHPLACE OF FATHER (city or town) Sweeden
(State or Country)
12. MAIDEN NAME OF MOTHER Allice Massie
13. BIRTHPLACE OF MOTHER (city or town) Bismarck Mich
(State or Country)

14. Informant Mathilda Matson
(Address) Kellogg Ida

15. Filed Mar 11, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to March 8, 1930
that I last saw him alive on March 8, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of —
Was there an autopsy? NO
What test confirmed diagnosis? Physical Examination
(Signed) [illegible], M. D.
March 10, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida | Date of Burial Mar 11 1930

20. Undertaker R. L. Stard | Address Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70322

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 24

(No. Residence.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Leo J. Dotson

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lavonne Dotson

6. DATE OF BIRTH (month, day and year) Sept. 23 - 1899

7. AGE Years 30 Months 6 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fremont Rest.

9. BIRTHPLACE (city or town) (State or country) Nebr.

PARENTS

10. NAME OF FATHER John Noble Dotson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Anna Garner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Virginia

14. Informant Dean Dotson

(Address) Wallace, Idaho.

15. Filed Mar 11, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 7, 1930

that I last saw him alive on March 7, 1930

and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Physical Examination

(Signed) R. Werlich, M. D.

March 7, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sutherland Nebr. Date of Burial Shipped March 11 1930.

20. Undertaker J. A. Bower Ward Ind Co. Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70323

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1017
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

185

2. FULL NAME Chas. Gulickson
(a) Residence. No. Wallace, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 82 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Prospector.

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant Wm Cossmerith
(Address) Mullan, Idaho.

15. Filed Mar 10, 1930. J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 6. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 6, 1930
that I last saw him alive on March 5, 1930
and that death occurred, on the date stated above, at 1:30 a m.
The CAUSE OF DEATH* was as follows:
Contusion r. hip & shock from fall on sidewalk
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Extreme Arteriosclerosis Gross.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
3/8/30, 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho | Date of Burial: March 1930

20. Undertaker J. A. Bean Ward Mud. Co. | Address: Wallace, Idaho

RECEIVED APR 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70324

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace, Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Chas B Lord

74A

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Wallace Hospital Record
(Address) Wallace, Idaho

15. Filed Mar 8, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 20, 1930, to March 4, 1930
that I last saw him alive on March 4, 1930
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Physical examination

(Signed) R Ellerich M. D.
March 5, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho — Date of Burial: March 8 1930
20. Undertaker: J. A. Brown Ward Undertaking — Address: Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70325

PLACE OF DEATH
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

71B

2. FULL NAME Helen Moira McGuire

(a) Residence. No. Victor Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 16 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Victor Idaho
(State or country)

PARENTS

10. NAME OF FATHER Dennis F. McGuire
11. BIRTHPLACE OF FATHER (city or town) Des Moines
(State or Country) Iowa
12. MAIDEN NAME OF MOTHER Dorothy B. Cowen
13. BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or Country) Big Horn Wyo.

14. Informant D. F. McGuire
(Address) Victor Idaho

15. Filed 5-2-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-30, 1930, to 3-30, 1930
that I last saw her alive on 3-30, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows: [illegible]
Meningitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. C. Parkinson M. D.
4-1-, 1930 (Address) Driggs Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Victor Cemetery	4-1- 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MA
WRITE PLAINLY, WITH ING INK—THIS IS A PERMANENT RECORD
ERVED FOR BINDING

FORM V. REC'D MAY 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 26326
Registered No. 4

1. PLACE OF DEATH
County of Teton
City of Victor
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola L. Mc. Iver
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 9 (Day) 1908 (Year)

7. AGE: 1 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION: —
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dennis J Mc. Iver

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Dorothy B. Cover

13. BIRTHPLACE OF MOTHER (State or Country): Big Horn ~~Idaho~~ Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dennis J Mc. Iver
(Address) Victor, Idaho.

15. Filed 5 – 2 – 1930 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 30 1930, to Mch. 30 1930, that I last saw her alive on Mch. 30 1930, and that death occurred on the date stated above, at 2.00 P.M.
The CAUSE OF DEATH* was as follows:

Meningitis Tuberculosa
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Gastro-enteritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. T. C. Tedder M. D.
3/31 1930 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Cemetery, Victor, Ida. DATE OF BURIAL: Apr. 1 1930

20. UNDERTAKER ..... ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70329

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry M. Sheldon

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Sheldon

6. DATE OF BIRTH (month, day and year): May 17-1861

7. AGE: Years 68 | Months 11 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Dubuque Iowa

PARENTS
10. NAME OF FATHER: John Sheldon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Jean Garwood
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Penna.

14. Informant (Address): Mrs Elizabeth Sheldon Esterville Iowa

15. Filed 4-19, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ only on ....., 19...., ~~to~~ 4/26, 1930
that I last saw him alive on 4/26, 1930
and that death occurred, on the date stated above, at 12:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Far advanced pulmonary tuberculosis - bilateral

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
unknown (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A. A. Morrison, M. D.
April 29, 1930 (Address) Buhl, Idaho

19. Place of Burial, Cremation, or Removal: Buhl, Idaho | Date of Burial: 4/30 1930

20. Undertaker: J. Johnson | Address: Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70330

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No.

(No.) 101 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Eliza Jane Crandall.

(a) Residence. No. Buhl Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3 1872

7. AGE Years 57 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Kim Rich Baxter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant F E Crandall
(Address) Buhl Ida

15. Filed Apr. 23, 1930 J. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 - 17, 1930, to 4 - 29, 1930
that I last saw her alive on 4 - 29, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo Jennings M. D.
4 - 23, 1930 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal: Driggs Idaho
Date of Burial: April 24 1930

20. Undertaker: Merville D Rugg.
Address: Buhl, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70332

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

159e

2. FULL NAME Baby Converse

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 22-1930

7. AGE Years — Months — Days — If LESS than 1 day, hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Filer Idaho

PARENTS
10. NAME OF FATHER Gilbert Converse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Dorothy Mark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebr

14. Informant Gilbert Converse
(Address) Buhl Ida

15. Filed 3-24, 1930 J. H. Mcarthy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 22 (Month) Mar (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth, 19, to death, 19
that I last saw her alive on 22 Mar, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral pressure - duration of life - 30 minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Never breached
(Signed) J. W. MacManus, M. D.
22-3-1930 (Address) Buhl, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Cemetery — Date of Burial: 3/23 1930

20. Undertaker: Neville D. Rugg — Address: Buhl, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70333

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Sarah Maria Davis

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Davis

6. DATE OF BIRTH (month, day and year) Aug 30 - 1841

7. AGE Years 88 Months 6 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER Wesley West Wyatt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dent Knox
12. MAIDEN NAME OF MOTHER Salina James
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Mrs Winnifred Newman BUHL - Ida

15. Filed Mar 21, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 — 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to 19-Mar, 1930
that I last saw her alive on 29-Mar, 1930
and that death occurred, ~~on the date stated above~~ 20-Mar, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. W. MacMannon M. D.
Mar 21, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida
Date of Burial 3/21 1930

20. Undertaker L. Johnson
Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70234

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2-087
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pearl L. Nipper 97

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jesse Nipper

6. DATE OF BIRTH (month, day and year) Nov. 20-1888

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Custer Co. Idaho

PARENTS

10. NAME OF FATHER John E Swanby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Mattie Cowden
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know

14. Informant Jesse Nipper
(Address) Buhl

15. Filed 5-12 1930 J. F. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 — 9 — 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
3-Mar —, 1930, to 9-Mar —, 1930
that I last saw h[illegible] alive on 9-Mar, 1930
and that death occurred, on the date stated above, at 5 45 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Eclampsia following pregnancy miscarriage at 5 months

45&50 minutes
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Miscarriage
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) D W Mac Manning, M. D.
12-May, 1930. (Address) Buhl, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Ida.	5/11 1930
20. Undertaker L. Johnson	Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70385

PLACE OF DEATH
County of Twin Falls
City of Do.

Registration District No. 37
Primary Registration District No. 2082
(No. White City Tourist Park)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

Coughlin 9

2. FULL NAME Harry Calvin Halstead
(a) Residence. No. White City Tourist Park St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6. DATE OF BIRTH (month, day and year) Feb 1st 1930

7. AGE — Years | Months 2 | Days 27 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho.

PARENTS
10. NAME OF FATHER Harry Halstead
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Myrtle Waldo
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Harry Halstead
(Address) Twin Falls, Idaho

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-27, 1930, to 4-28, 1930
that I last saw him alive on 4-27, 1930
and that death occurred, on the date stated above, at 4:20 A.m.
The CAUSE OF DEATH* was as follows:
Whooping Cough
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John T. Coughlin, M. D.
4-29, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery | Date of Burial: 4/30/30

20. Undertaker: Paul Beer | Address: Twin Falls

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70336

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1080
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. R Scott

1000

2. FULL NAME Maurice La Grande Crowley

(a) Residence. No. 951 Eden st St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21 1920

7. AGE	Years	Months	Days	If LESS than 1 day,
	9	5	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) x
(c) Name of employer x

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER J. N. Crowley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) California
12. MAIDEN NAME OF MOTHER Jennie Hunsaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mr & Mrs J. N. Crowley.
(Address) 951 Eden St Twin Falls Ida.

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24, 1930, to Apr. 28, 1930
that I last saw him alive on April 28, 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. R. Scott M. D.
4-29, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	4-30 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70337

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) Dr C.
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

187

2. FULL NAME Carrie N Wallace

(a) Residence. No. 1225 6th E St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 4 / 1874

7. AGE Years 57 Months — Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER Philip Gingran
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Elizabeth Orwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mr Wallace
(Address) 1225 6th Ave E Twin Falls

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 23 1930 4-30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to Apr. 23, 1930
that I last saw her alive on Apr. 23, 1930.
and that death occurred, on the date stated above, at 3.30 P.m.
The CAUSE OF DEATH* was as follows: Streptococcus infection of Throat
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Infected tonsils Several
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no Throat
What test confirmed diagnosis? Culture from
(Signed) John H Langken M. D.
4-24, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Apr 25 1930

20. Undertaker F C Drake Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70338

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls.

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

117

2. FULL NAME Lee Sabala

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Spanish	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 - 1902

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	1	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Valentine Barinaga

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10. NAME OF FATHER Juan Baliste Sabala
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Francisca Kobeaga
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Frank Sabala
(Address) Twin Falls. Ida

15. Filed May 8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17th, 1930, to April 18, 1930
that I last saw him alive on April 18th, 1930
and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:
Appendicitis Chronic with Acute Exacerbation
Retrocecal (gangrenous) attached to duodenum.
Lead Eye urbation (duration) yrs. mos. 3 ds.
CONTRIBUTORY Toxemia + + + +
(Secondary)
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Twin Falls Co
Did an operation precede death? Yes Date of April 17/30
Was there an autopsy? No
What test confirmed diagnosis? Operation & Pathologist
(Signed) Duncan L Stevenson M. D.
4/19/30, 19..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	19
20. Undertaker	Address
White Mortuary Inc	Twin Falls. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70339

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2080
(No. Twin Falls Co. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1116

2. FULL NAME Louis Peter Sorensen

(a) Residence. No. Ranch. 2 miles S. E. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE Anna Martha Sorensen

6. DATE OF BIRTH (month, day and year) April 25 - 1889

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher, and
(b) General nature of industry, business, or establishment in which employed (or employer) employee of
(c) Name of employer Independent Meat Market

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER S. P. Sorensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Margaret Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs. Anna Sorensen
(Address) Twin Falls, Idaho

15. Filed 5-8, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1929, to Apr. 17, 1930
that I last saw h[illegible] alive on Apr. 17, 1930
and that death occurred, on the date stated above, at 6:00 A m.
The CAUSE OF DEATH* was as follows: Remarriage from Mucous membrane of Stomach following Gastro-jejunostomy (duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Duodenal ulcer
(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of April 4-30
Was there an autopsy? yes.
What test confirmed diagnosis?

(Signed) John P. Oughton M. D.
4-14, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	4-21 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70340

PLACE OF DEATH
County of Twin Falls. Registration District No. 37
City of Twin Falls. Primary Registration District No. 1085
(No. 1404 - 8th ave East) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Robert Bruce.

(a) Residence. No. 1404 - 8th ave east St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Addie Bruce.

6. DATE OF BIRTH (month, day and year) Dec 4 - 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	4	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgia

PARENTS
10. NAME OF FATHER James M. Bruce
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Carolina.
12. MAIDEN NAME OF MOTHER Jane Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Carolina.

14. Informant Mrs. Nora Cornelison
(Address) 1404 - 8th ave East

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1930 to Apr 14th 1930
that I last saw h-- alive on Apr. 13 M 1930
and that death occurred, on the date stated above, at 8:00 P. m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. 2 mos. 5 ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis General
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? c
Did an operation precede death? No Date of c
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W. Coughlin M. D.
4-17, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	4/17/30
20. Undertaker F. C. Drake	Address Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70341

Local Registrar's No. 165

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME F. F. Ruge

(a) Residence. No. Filer St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 9 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	9	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Grain Dealer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Geo. Ruge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Anna Lindt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Francis M. Ruge
(Address) Filer

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: —

Suicide.
Poison (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) F. L. Drake Coroner M. D.
....., 19... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Everly Iowa	May 15 1930

20. Undertaker F. C. Drake Address Twin Falls

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70342

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2082
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

dale

2. FULL NAME Baby Muter

(a) Residence. No. Edon St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 12 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Clifford L Muter
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Anna Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Clifford Muter
(Address) Edon

15. Filed 5-8-, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-12, 1930, to 4-12, 1930
that I last saw h[illegible] alive on 4-11, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows: Premature birth
at 8 mos
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John P Jacobs M. D.
4-14, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	Mar 15 1930

20. Undertaker T. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70343

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 31
Primary Registration District No. 2085
(No. 148 Oregon)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Anna Muten

(a) Residence. No. Eden St. Dr. Caughlin
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 18 1907

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Otto Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Nellie Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Clifford L. Muten
(Address) Eden

15. Filed 5-8-, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr (Day) 12 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from March 20 1930 to April 12 1930
that I last saw her alive on Apr 12 1930
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Post Partum
eclampsia
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Pregnancy
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) John K Brewster M. D.
4-14-30 (Address) Twin Falls Clinic

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho	Apr. 15 1930

20. Undertaker A E Funke — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70344

PLACE OF DEATH
County of Twin Falls
City of Hansen

Registration District No. 37
Primary Registration District No. 2081
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

45

2. FULL NAME Pina Elizabeth Mai
(a) Residence. No. Hansen R.F.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Mai
6. DATE OF BIRTH (month, day and year) Jan. 14 1873
7. AGE Years 57 Months 2 Days 28 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10. NAME OF FATHER Daniel Jordon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Christiena Sippel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Russia

14. Informant Peter Mai
(Address) Hansen R.F.D. #1

15. Filed 5-8, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930, to April 12, 1930
that I last saw her alive on April 11th, 1930
and that death occurred, on the date stated above, at 2:30 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma Colon (Splenic Flexure)
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Secondaries liver & lymph glands
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of Dec 6th 1929
Was there an autopsy? No
What test confirmed diagnosis? Op & Biopsy & Xray
(Signed) Duncan L. Flexman D.
April 13, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial 4/15 1930
20. Undertaker P. J. Grossman
Address Twin Falls

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76345

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
(No.) Hill 90
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura Maria Johnson
(a) Residence. No. Twin Falls, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John P. Johnson

6. DATE OF BIRTH (month, day and year) Aug 8-1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Henderson Co. Ill

PARENTS
10. NAME OF FATHER George M. Foote
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E. J. Johnson
(Address) Churchill, Idaho.

15. Filed 5-8-, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-10, 1930, to 4-3, 1930
that I last saw h~~er~~ alive on 4-3, 1930
and that death occurred, on the date stated above, at 10:15 P. m.
The CAUSE OF DEATH* was as follows:

Heart Failure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Churchill
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Hewitt L. C., M. D.
4-4, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	4-6 1930
20. Undertaker	Address
White Mortuary, Inc.	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20346

PLACE OF DEATH
County of Twin Falls.
City of Filer.

Registration District No. 37
Primary Registration District No. 2086
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

7HA

2. FULL NAME George W. Blakesley

(a) Residence. No. Filer. Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10-1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	8	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER Geo Blakesley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER × × ×
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) × × ×

14. Informant Ward Blakesley
(Address) Filer Idaho.

15. Filed 5-8, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to April 2, 1930
that I last saw him alive on April 2, 1930
and that death occurred, on the date stated above, at 12:35 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.

(duration) yrs. mos. 19 ds.
CONTRIBUTORY (Secondary) Arteria sclerosis.
(duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) F. A. Dwight, M. D.
April 2, 1930 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer	April 1930

20. Undertaker J. E. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 12 1930

PLACE OF DEATH

County of Twin Falls

City of " "

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70347

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No. 429 Walnut St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margarett Stoddard

(a) Residence. No. 429 Walnut St. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph F. Stoddard

6. DATE OF BIRTH (month, day and year): Dec. 14 1871

7. AGE: Years 57 | Months 1 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: John Robinson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): don't know

12. MAIDEN NAME OF MOTHER: Lucinda Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): don't know

14. Informant: Joseph F. Stoddard
(Address) 429 Walnut St. City

15. Filed 5-8, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-28-, 1930, to 3-31-, 1930, that I last saw h[illegible] alive on 3-31-, 1930, and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

R Side Paralysis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary): Haemmorage of Brain

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Exam

(Signed) W. H. Leete, M. D.

4-2-, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	April 3 1930
20. Undertaker	Address
T. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 70348
Registered No.

1. PLACE OF DEATH

Registration District No. 15
Primary Registration District No.

RECEIVED APR 19 1930

County of Valley
City of Near Cascade Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Rauch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Jan (Month) 6 (Day) 1856 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Muscatine Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A E Rauch
(Address) .....

15. Filed 3/23 1930 Stella Cain
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/19/30 19..., to 3/20/30 19...
that I last saw him alive on 3/20/30 19...,
and that death occurred on the date stated above, at 5:00 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 1 yrs. 0 mos. 1 ds.
Contributory (Secondary) Right Hemaplegia
(Duration) 5 yrs. 0 mos. 0 ds.

(Signed) Roscoe L Ward M. D.
County Physician
3/22 1930 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19...
Pasadena Calif	
20. UNDERTAKER Wm M Braley	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED MAY 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70350

PLACE OF DEATH
County of Valley
City of McCall

Registration District No. 15
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Robert L Page

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 61 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Theatre operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kansas

PARENTS
10 NAME OF FATHER: Jacob Page
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: ✓
13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓

14 Informant: A H Meyers
(Address) McCall Ida

15 Filed 4/12, 19 Stella Cain
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 11 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 10th, 1930, to April 11th, 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

an acute Heart attack following myocarditis of about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): arteriosclerosis (Hardening of Arteries) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no.
What test confirmed diagnosis? only observation.
(Signed) Don S. Kimberly, M. D.
4/12, 1930 (Address) McCall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: McCall Idaho
Date of Burial: April 13 1930

20. Undertaker: Wm McBratney
Address: AS Robb

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 12 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 70351

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 88

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irene Winn Greene

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Maud

6. DATE OF BIRTH. (Month) April (Day) 22 (Year) 1864

7. AGE ....66.... Yrs. ....Mos. ....14.... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER George Hamblin

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) x A D Greene

(Address) .....

15. Filed 5-10-30 191.... R W Pretsman Local Registrar

MEDICAL CERTIFICATE OF DEATH

124

16. DATE OF DEATH May (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1930, to May 5 1930, that I last saw her alive on May 5 1930, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis — Uremia due to Anuria

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R W Pretsman M. D.

.....19..... (Address) Cambridge Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salubria

DATE OF BURIAL: 5-7 1930

20. UNDERTAKER: J A Hendelson

ADDRESS: Cambridge

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ... statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

RECEIVED MAY 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70352

70352

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 54

(No. 102)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elgie Livingston Johnston

(a) Residence. No. 222 Aven St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lottie Johnston

6. DATE OF BIRTH (month, day and year) July 13, 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	9	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Keasaqua
(State or country) Iowa

PARENTS

10. NAME OF FATHER Jame Johnston

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Rhode Moore

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Iowa

14. Informant J. W. Griffith
(Address) Caldwell, Idaho

15. Filed 5-16-, 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14-30, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Drowning. Accidental.

No inquest.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] Coroner., M. D.

5-15-30, 19 Caldwell Idaho
(Address)

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 5-18-30 19

20. Undertaker: Paul L. Case — Address: Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED MAY 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elzie Livingston Johnston

(a) Residence. No. 222 Owen St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lottie Johnston

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	9	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Keosauqua
(State or country) Iowa

PARENTS

10. NAME OF FATHER James Johnston
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Rhode Moore
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Iowa

14. Informant J. R. Griffith
(Address) Caldwell Idaho

15. Filed 5-16-, 1930. John S. Meyers M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Drowning. Accidental.
No Inquest
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) Paul L. Case Coroner M. D.
5-15-, 30, 19... (Address) Caldwell, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	5-18 1930

20. Undertaker Paul L. Case Address Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

7035-3

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. ..... (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredrick Earl Wilber

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mable Wilber

6. DATE OF BIRTH (month, day and year) Jan. 15, 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	2	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Ottawa
(State or country) Kansas

PARENTS

10. NAME OF FATHER Alva M Wilber
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Elizabeth Bryant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mable Wilber
(Address) Burley Ida.

15. Filed 4-12, 1930 I. H. Collier Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 8, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to April 8, 1930
that I last saw him alive on April 8, 1930
and that death occurred, on the date stated above, at 7 [illegible] m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Transverse Colon

(duration) about 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of Feb 10-20
Was there an autopsy? no
What test confirmed diagnosis? Microscopic examination of tumor
(Signed) Frederick Earl Wilber, M. D.
....., 19..... (Address) Burley Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Ottawa Kan.	April 10 1930
20. Undertaker	Address
D. E. Johnson	Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

70354

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70354

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 144

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Elizabeth Van Derwerf.

(a) Residence. No. 1331 Denver St
(Usual place of abode.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June. 25. 1845.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84.	10	25.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Holland.

PARENTS

10. NAME OF FATHER John Van Der Meulen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland,
12. MAIDEN NAME OF MOTHER Catherine Wink.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Holland.

14. Informant Mrs. John Bromet.
(Address) 1331. Denver Street, Boise, Idaho.

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20 '30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 '30, 1930 to May 20 '30, 1930
that I last saw her alive on May 20 '30, 1930
and that death occurred, on the date stated above, at 6.30 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dilatation of Heart
Death came suddenly-patient
Nursing relief Sedative well.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility -
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Hall Brooks M. D.
May 20, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	May. 22. 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

40355

DO NOT WRITE IN THIS SPACE

State File No. 20355

PLACE OF DEATH
County of Minidoka
City of Paul

Registration District No. 19
Primary Registration District No. 2015

Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William H. Lowery

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	3	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER William B Lowery
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Eden Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Eden Hansen
(Address) Paul Idaho

15. Filed 5-12, 1930 Ed E. Elsmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Tumor on brain

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J B Kennagy, M. D.
5-13-, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paul Cemetery	May 7 1930
20. Undertaker W. J. Gardner	Address Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

70357

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 147
(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma P. French
(a) Residence. No. 717 W 14 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 14-1850
7. AGE 79 Years Months 9 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wilmot Wis

PARENTS
10. NAME OF FATHER George Penney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Lonie
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Dr. P. P. French 1407 Hays st Boise Ida

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to May 20, 1930
that I last saw her alive on May 20 1930
and that death occurred, on the date stated above, at 8 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility
Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? usual
(Signed) Attorney, M. D.
5/21, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial May 22 1930
20. Undertaker Summers & Kreks
Address Boise Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

70358

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70358

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 157
(No. 1317 Leadville)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George H. Landers.

(a) Residence. No. 1317 Leadville St.
(Usual place of abode.)
Length of residence in city or town where death occured. 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Essie Landers.

6. DATE OF BIRTH (month, day and year) April 19th 1875

7. AGE Years.	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shingler.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairbow, Minn.

PARENTS

10. NAME OF FATHER Dwain Landers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y.

14. Informant (Address) Mrs. G.H.Landers. Boise, Idaho.

15. Filed June 2, 1930 W. H. Rhoden Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to May 28, 1930, that I last saw h.... alive on May 28, 1930, and that death occurred, on the date stated above, at 10:40 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hereditary Chorea Spinal Paralysis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heredetary

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Was Case of Polio

(Signed) Wm. E. Cochran M. D.
5-31-30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5/30/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAY 31 1930

70359

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70359

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

196

2. FULL NAME Frank Baran

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Agelia Baran

6. DATE OF BIRTH (month, day and year) Aug 23, 1887

7. AGE 42 Years | Months 9 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Motorman
(c) Name of employer B.H. & S. Co.

9. BIRTHPLACE (city or town) Novi Vinodol
(State or country) Aug 23, 1887 Jugo-Slavia

PARENTS
10. NAME OF FATHER John Baran
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jugo-Slavia
12. MAIDEN NAME OF MOTHER Annie Maichi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jugo-Slavia

14. Informant Nako Krikovich
(Address) Kellogg, Idaho

15. Filed May 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at Mohawk
The CAUSE OF DEATH* was as follows:
Electrocuted by striking charged pole
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) N C Mowery Corp
5/27, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Butte, Montana | Date of Burial May 29, 1930

20. Undertaker M. C. Thornhill | Address Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

70360

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70360

PLACE OF DEATH

County of Idaho
City of Canfield
Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 14
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Genevieve Shinn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Benjamin A. Shinn

6. DATE OF BIRTH (month, day and year) March 29th. 1864

7. AGE	Years	Months	Days	If LESS than 1 day,
	66		9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Not known
(State or country) Maine

PARENTS

10. NAME OF FATHER Miller

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Lord

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) England

14. Informant Ray Shinn
(Address) Canfield Idaho

15. Filed 5/16/30., 19.... B. Chipman
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 8th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct. 16, 1929, to Oct. 17, 1929
that I last saw her alive on Oct. 17, 1929
and that death occurred, on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH* was as follows:
Chronic Interstital Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary findings

(Signed) B. Chipman, M. D.
5/16/, 1930 (Address) Grangeville, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canfield, Idaho.	April 10 - 19 30
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1930

70361

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70361

PLACE OF DEATH
County of Canyon
City of Caldwell Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 57
(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Lou E. McCarty
(a) Residence. No. 709 Everett St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert S. McCarty
6. DATE OF BIRTH (month, day and year): Sept 22
7. AGE: Years 67; Months 8; Days —; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sales Lady
(b) General nature of industry, business, or establishment in which employed (or employer): C C Anderson Comp.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pleasant Grove Pa
PARENTS
10. NAME OF FATHER: James Potter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Mildred Vaughn
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Virginia
14. Informant (Address): Miss Ethel O. Ward 608 Grant Caldwell Ida
15. Filed 5-25-, 1930 John S. Reeves Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8-35 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. Sudden mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
5/23, 1930 (Signed) Fred Coates, M. D.
(Address) Caldwell

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 5/25 1930
20. Undertaker: C. V. Peckham Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

70362

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 160
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah A. Confer
(a) Residence. No. Boise, Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. W. Confer

6. DATE OF BIRTH (month, day and year) June 3-1874

7. AGE Years 55 Months 11 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS
10. NAME OF FATHER Daniel Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Sarah Catherine Murphy
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Am.

14. Informant (Address) A W Confer Jordan Valley Ore

15. Filed 6-2, 1930 S. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/19, 1930, to 5/28, 1930
that I last saw her alive on 5/27, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Toxemia.
Tubercular dorsal spine
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Probable mediastinal tumor (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical
(Signed) Ralph Falk M. D.
5/31, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 6/1 1930

20. Undertaker Schreiber & W. Carr Address Boise

Falk.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

70363

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70363

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 46

(No. U.S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh GIBSON

(a) Residence. No. ..... St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47	xx	xx	xx	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer) xx

(c) Name of employer

9. BIRTHPLACE (city or town) N. Dak.
(State or country)

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant H. Book

(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 6-2, 1930 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1930 to May 31, 1930
that I last saw him alive on May 31, 1930
and that death occurred, on the date stated above, at 6:35 a.m.
The CAUSE OF DEATH* was as follows:
Tbc. pulmonary, chronic, active, far advanced.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) xx

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? no Date of

Was there an autopsy? 10:30 a.m. May June 1, 1930

What test confirmed diagnosis? Clinically

(Signed) F.C.SMITH, Reg.Med.Officer M. D.

June 2, 1930 (Address) U.S.Vet.Bureau
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shipped Date of Burial 6/2/30 19
Kellogg, Idaho

20. Undertaker Wm. McBratney. Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

70364

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70364

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 45

PLACE OF DEATH
County of Ada
City of Boise
(No. U.S.Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

81

2. FULL NAME ORSON OSCAR WEST

(a) Residence. No. 160 Idaho Street St. Pocatello, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 25, 1898

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work welder
(b) General nature of industry, business, or establishment in which employed (or employer) XX
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER XX

11. BIRTHPLACE OF FATHER (city or town) XX
(State or Country)

12. MAIDEN NAME OF MOTHER XX

13. BIRTHPLACE OF MOTHER (city or town) XX
(State or Country)

14. Informant H. Bock
(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 6-2, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 29, 1926, to June 2, 1930
that I last saw him alive on June 2, 1930
and that death occurred, on the date stated above, at 5:10 P. m.
The CAUSE OF DEATH* was as follows:
Tbc. pul. chronic, active, far adv. C.

(duration) yrs. mos. ds.

CONTRIBUTORY XX
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? XX
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinically
(Signed) E.C.SMITH, Reg. Medical Officer M.D.
June 3, 1930 (Address) U.S.Veterans' Bureau
Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: American Falls, Idaho — Date of Burial: Shipped 6/3/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

7036S

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20365

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 124

2. FULL NAME Flora Hervey Readoch

(a) Residence. No. 1614 west Jefferson St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles F Readoch

6. DATE OF BIRTH (month, day and year): Nov. 7th 1882

7. AGE: Years 47 | Months 5 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hastings Mich

PARENTS
10. NAME OF FATHER: Abram Hervey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Margaret Loffel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: Charles F Readoch
(Address) Boise Idaho

15. Filed 5-1, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH, April 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 28, 1930
that I last saw h[er] alive on April 28, 1930
and that death occurred, on the date stated above, at 5 P., m.
The CAUSE OF DEATH* was as follows:
Acute Septicemia of pelvic origin
also acute mania
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) P. P. French M. D.
April 29, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Johns Cemetery — Date of Burial: 5/1 1930
20. Undertaker: Schreiber & McCain — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED JUN 7 1930

70367

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 70367
Registered No. 66

1. PLACE OF DEATH

County of Kootenai

City of New Worley

If death occurs away from usual residence, give facts called for under special information.

Fred Ida.

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Ham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word)

6. DATE OF BIRTH. May (Month) 18 (Day) 1860 (Year)

7. AGE 69 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER John Ham

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. G. Ham
(Address) Fred Ida

15. Filed May 7 1930

H. J. Sturges M.D.
Local Registrar.

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH May (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18th 1930 to May 2 1930 that I last saw him alive on at time of death and that death occurred on the date stated above, at 12:15 a M.

The CAUSE OF DEATH* was as follows:
Chronic Dilatation of Heart

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonic Hemorrhage 10 hrs.

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. J. Henington M. D.

19.... (Address) Woolley Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Sprague Wn.

DATE OF BURIAL May 4 1930

20. UNDERTAKER W. S. Jacques

ADDRESS Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

70368

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70368

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Chloe Sweet

(a) Residence. No. 312 - 8th Ave E. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Sweet

6. DATE OF BIRTH (month, day and year) Nov 14 - 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Port Byron New York

PARENTS

10. NAME OF FATHER Robert Vaughn Sweet
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Julia Ferris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Irvin Sweet
(Address) R.F.D. #1 Twin Falls

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1930, to May 27, 1930
that I last saw her alive on May 27, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Abdom. Tumor
Myocardial Degeneration
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr John A Morgan, M. D.
May 27, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	5-29 1930
20. Undertaker: White Mortuary Inc	Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

70369

RECEIVED JUN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70369

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

✓ 129

2. FULL NAME John R. Smith.

(a) Residence. No. St. Orchards.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Widower.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24th, 1844.

7. AGE Years: 85. Months: 11. Days: 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer): Live stock.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: George Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland.
12. MAIDEN NAME OF MOTHER: -------.McNutt.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant
(Address) Lewiston, Idaho.

15. Filed June 5, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1st, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1928, to Apr, 1930
that I last saw him alive on Mar 28, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Chronic nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
4/2/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 4/3/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

70370

DO NOT WRITE IN THIS SPACE
State File No. 20320

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 41

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Richard M. SARTAIN

(a) Residence. No. Craig, Colorado St.
(Usual place of abode)
Length of residence in city or town where death occurred. x yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6. DATE OF BIRTH (month, day and year) May 29, 1879

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	50	11	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant M. Cornelius
(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 5-21, 1930 W. H. Rhoden
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to May 20, 1930, that I last saw h im alive on May 20, 1930, and that death occurred, on the date stated above, at 2:15 A.M.

The CAUSE OF DEATH* was as follows:

General Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atrophic cirrhosis of liver with ascites.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx

Did an operation precede death? yes Date of 4-22-30

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & Laboratory

(Signed) F. C. SMITH, Reg. Med. Officer M. D.

5-21-30, 19 (Address) U.S. Vet. Bureau Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Evansville, Indiana	5-21-30

20. Undertaker	Address
Jos. Schaefer & Son	Evansville, Ind.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

70371

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12821

PLACE OF DEATH
County of Bingham
City of Blackfoot. I
Registration District No. 121
Primary Registration District No. 1902
Local Registrar's No. 62
(No. In Burks Hosp. Eccles Bldg. 1012
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesus Hernandez
(a) Residence. No. Near Sugar Factory St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Mexican	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Hernandez

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	67			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Sugar Beets
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant E. Hernandez
(Address) Blackfoot. Ida.

15. Filed May 10, 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 9, 1930
that I last saw him alive on May 9, 1930
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
May 10, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	5-12- 19
20. Undertaker	Address
Modern Mortuary,	Blackfoot.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70372

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 131

(No. St. Alphonsus Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

144 c

2. FULL NAME John L Laucks

(a) Residence. No. 235 N. Spring St. Ave
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Dont know

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. — 1866

7. AGE Years 63 Months 6 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER William H. Laucks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Laura E. Fry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Mrs. A. H. Ostner
(Address) Boise, Idaho

15. Filed 5-10, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930

that I last saw him alive on May 8, 1930

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Shock from auto accident
concussion brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Chas. V. Gemmy M. D.

May 9, 1930 (Address) Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 5/10 1930

20. Undertaker: Schreiber & McCann — Address: Boise, Idaho

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 10828

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 145

(No. St Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

62

2. **FULL NAME** Edna Smithers Walchli.

(a) Residence. No. Melba Idaho. St. Melba Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred. E. Walchli.

6. DATE OF BIRTH (month, day and year) Dec. 27. ~~1890~~ 1889

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40 ~~39~~	4	24.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan.

PARENTS

10. NAME OF FATHER William Smithers.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Unknown.~~ Canada

12. MAIDEN NAME OF MOTHER Catherine Mc Gillis.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) ~~Unknown.~~ Canada

14. Informant (Address) Fred. E. Walchli. Melba, Idaho.

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-11, 1929, to 5-21, 1930
that I last saw her alive on 5-21, 1930
and that death occurred, on the date stated above, at 2:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Adrenal Glands

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) O. F. Swindell, M. D.
5-21, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Kalispell, Montana.	May. 22. 1930.
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

V. S. No. 3—6M—1-30.

Original Record for State Registrar

STATE OF MONTANA
Bureau of Vital Statistics
Standard Certificate of Death

Do not write in this space

1. PLACE OF DEATH

County..... Registered No.....

Township..... or Village.....or

City..... No..... St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred.....yrs.....mos.....days. How long in U. S. if of foreign birth? .....yrs. .....mos. .....days

2. FULL NAME Edna Smithers Walchli

(a) Residence: No..... St., ... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Fred E. Walchli

6. DATE OF BIRTH (month, day, and year) 1889

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
40	4	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper,** etc. Home W'ife

9. Industry or business in which work was done, as **silk mill, saw mill, bank,** etc. @ Home

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (city or town) (State or country) Alpena Michigan

FATHER

13. NAME William Smithers

14. BIRTHPLACE (city or town) (State or country) Canada

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country) Canada

17. INFORMANT.....
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place..... Date....., 19.....

19. UNDERTAKER.....
(Address)

20. FILED....., 19..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) May - 21, 19 30

22. I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....

I last saw h..... alive on....., 19....., death is said to have occurred on the date stated above, at .....m.

The **principal cause of death** and related causes of importance in order of onset were as follows: **Date of onset**

.....

.....

.....

.....

.....

Contributory causes of importance not related to principal cause:

.....

.....

.....

Name of operation....., Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (**violence**) fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in **industry,** in **home,** or in **public place.**

.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

8—209
V. S. No. 98

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70374

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 143

(No. St Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1013

2. **FULL NAME** Caroline Oshlo.

(a) Residence. No. Near Collister Station. St.

(Usual place of abode.)

Length of residence in city or town where death occured. 1 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 10. 1860.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	0	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Norway.
(State or country)

PARENTS

10. NAME OF FATHER Ferdinand Olson.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Norway.

14. Informant Mrs. Bertha. F. Ayers.
(Address) Box. 866. Boise, Idaho.

15. Filed 5-19, 1930 W. R. Rose
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 18, 1930
that I last saw h.. alive on 5-18, 1930
and that death occurred, on the date stated above, at 11 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia & Cardiac failure.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Fracture of left hip

& Senility (duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herald T. Rokus M. D.

5-19, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Council Bluffs, Iowa.	May. 22. 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10325

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 142
(No. St. Alphonsus Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Blecha
(a) Residence. No. 4½ mi. west. Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.) Nampa, Idaho
Length of residence in city or town where death occured. 2 yrs. 3 mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 16th 1914

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	2	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Vincent Blecha
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Checho Slavockia
12. MAIDEN NAME OF MOTHER Anna Trebnar
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Checho Slavockia

14. Informant Mr. Vincent Blecha
(Address) Nampa, Ida

15. Filed 5-17, 1930 W. J. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5-16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-3, 1930 to 5-16, 1930
that I last saw her alive on 5-16, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute lymphatic leukemia
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) — yrs. — mos. 5 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? yes Date of 5-14-30
Was there an autopsy? No What test confirmed diagnosis? Physical & laboratory findings
(Signed) L. L. West M. D.
5-16, 1930 (Address) 413 E. Alma Bldg.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	19
20. Undertaker	Address

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70376

PLACE OF DEATH
County of Ada
City of ~~Jamestown~~ Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 141
(No. St Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Charles E Thum
(a) Residence. No. 205 N 4th St. Boise Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed or divorced HUSBAND of (or) WIFE of Laura Perrault Thum
6. DATE OF BIRTH (month, day and year) 9-27-1870
7. AGE 59 Years Months 7 Days 17 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Jamestown NY
PARENTS
10. NAME OF FATHER — Thum
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown
14. Informant J. Perrault
(Address) 411 Bannock St Boise
15. Filed 5-17, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-21-, 1926, to 5-14-30, 19..
that I last saw him alive on 5-14-30, 19..
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) 16 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Diabetic Coma
(duration) ..... yrs. ..... mos. 3 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Blood Chemistry, Urinalysis, Abnormal Tension
(Signed) [illegible] M.D.
5-16-30, 19.. (Address) Boise Idaho
Ernest E. Lanbaugh

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial 5/17 1930
20. Undertaker Schreiber & McCann — Address Boise, Ia

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alphonsus Hospital, If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 20328

Local Registrar's No. 139

2. FULL NAME James Emmerson

(a) Residence No. 90 St. Idaho City, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 70			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work X X

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) X X

PARENTS

10. NAME OF FATHER X X

11. BIRTHPLACE OF FATHER (city or town) (State or Country) X

12. MAIDEN NAME OF MOTHER X X

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. Schreiber
(Address) Boise

15. Filed 5-14, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 12, 1930, that I last saw him alive on May 12, 1930, and that death occurred, on the date stated above, at 8 P.M. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal Disease & Chronic Valvular heart disease.

? (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic Heart.

? (duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examin.

(Signed) Herald T. Rohrs, M. D.

5-14-, 1930 (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho City Ida	5/15 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada/
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 138
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

183

2. **FULL NAME** Ruth Andregg.
(a) Residence. No. Boise, Idaho R#3. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) July 8th 1921

7. AGE Years: 8 Months: 10 Days: 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: In School.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dry Creek.

PARENTS

10. NAME OF FATHER: Herman F. Andregg.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Minnesota.
12. MAIDEN NAME OF MOTHER: Violet Robison.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Pa.

14. Informant (Address): Mrs. H. F. Andregg. Boise, Idaho. R#3.

15. Filed 5-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13th 1930 (Month) (Day) (Year), 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 1 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental Gunshot wound of Left Knee
Traumatic & Surgical Shock (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 5/12/30
Was there an autopsy? no
What test confirmed diagnosis? Imaged findings
(Signed) James L. Stewart, M. D.
5/13/30, 19..... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/14/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10880

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 137
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Crawford Daly

(a) Residence. No. 2119 N. 19. St.
(Usual place of abode.)
Length of residence in city or town where death occured 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

101B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12-1845

7. AGE: Years 84 | Months 0 | Days 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Mathew Crawford
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown,
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown,

14. Informant (Address): James Daly 2119 N. 19 St Boise Idaho

15. Filed 5-14-1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 13, 1930
that I last saw her alive on May 10, 1930
and that death occurred, on the date stated above, at 10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) P. O. French, M. D.
May, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Dry Creek Cemetery — Date of Burial: May 15 1930
20. Undertaker: Summers & Trefz — Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10381

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 136
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs. Opal Shaffer
(a) Residence. No. Star, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Olaf Shaffer.

6. DATE OF BIRTH (month, day and year): May 11th 1913

7. AGE: Years 17, Months 0, Days 1. If LESS than 1 day, ---- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Middleton, Idaho.

PARENTS

10. NAME OF FATHER: Henry E. Bowman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.
12. MAIDEN NAME OF MOTHER: Margory Baird.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Mo.

14. Informant (Address): Henry E. Bowman. Middleton, Idaho.

15. Filed 5-13, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 12th 1930 (Month) (Day) (Year), 19..

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to 5/12, 1930
that I last saw her alive on 5/12, 1930
and that death occurred, on the date stated above, at 5 AM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) abortion

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Apr 11/30
Was there an autopsy? no
What test confirmed diagnosis? Phy. Findings & Surgery
(Signed) Alfred Budge Jr., M. D.
5/12/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/14/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 10382

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 135

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Newton Henry States.

(a) Residence. No. Boise, Idaho Route #3. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Loa States.

6. DATE OF BIRTH (month, day and year) February 25th 1893

7. AGE Years	Months	Days	If LESS than 1 day, ... min.
37	2	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Delta, Colorado.

PARENTS

10. NAME OF FATHER H. L. States.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Hattie Castle.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) N.Y.

14. Informant (Address) Mrs. Loa States. Boise, Idaho.

15. Filed 5-13, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from May 31, 1929, to May 10, 1930 that I last saw h[illegible] alive on May 10, 1930 and that death occurred, on the date stated above, at 9:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) W. L. Driggs, M. D.

5/12/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/12/30, 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Irmaine

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 133
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Jasens Marlatt 92

(a) Residence. No. 616 S-16 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29-1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS

10. NAME OF FATHER Charles Marlatt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Marie Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) Charles Marlatt 616 S. 16 st Boise Ida

15. Filed 5-12, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 (Hour) 1930, to May 10, 1930
that I last saw him alive on May 10, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Double Thrombosis of femoral arteries (both sides)

Probable (duration) — yrs. — mos. 3 ds.
CONTRIBUTORY (Secondary) Probable cause, embolism of pulmonical vessels (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis Gangrene of toes.
(Signed) Harmon G. Brennan M. D.
May 12, 1930 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hays Creek Cemetery	May 11 1930
20. Undertaker	Address
Summers & Kuhn	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20384

Registration District No. 2
Primary Registration District No. 1004
(No. St. Rukes)
Local Registrar's No. 132

PLACE OF DEATH
County of Ada
City of Boise

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack Benjamen Brookler

(a) Residence No. 1016 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Bertha Brookler

6. DATE OF BIRTH (month, day and year) Mar 16 - 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	2	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bot Factory worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) La Grande
(State or country) Oregon

PARENTS

10. NAME OF FATHER J. B. Brookler
11. BIRTHPLACE OF FATHER (city or town) Williamsport
(State or Country) Pa.
12. MAIDEN NAME OF MOTHER Dina Cantrel
13. BIRTHPLACE OF MOTHER (city or town) Washington
(State or Country)

14. Informant J. B. Brookler
(Address) La Grande Oregon

15. Filed 5-12, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 10, 1930
that I last saw h~~im~~ alive on May 10, 1930
and that death occurred, on the date stated above, at 2 30 p.m.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J A Springer, M. D.
5/12, 1930 (Address) Burke Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	5/15 1930

20. Undertaker C D Bucknum
Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 0385

PLACE OF DEATH
County of Ada.
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 129
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME John S. Elam.
(a) Residence. No. 1010 Thatcher St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Elam.
6. DATE OF BIRTH (month, day and year) January 16th 1854
7. AGE Years 76 Months 3 Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Woobern, Ill.

PARENTS
10. NAME OF FATHER Francis M. Elam.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Nancy Walker.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) Laurel Elam. Boise, Idaho.
15. Filed 5-9, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9th 1930, 19 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 9th, 1930
that I last saw him alive on May 8th, 1930
and that death occurred, on the date stated above, at 1:30A m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis (parenchymatous)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged prostate, obstructing urethra - Hemorrhage (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of May 8th
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) J. M. Taylor, M. D.
5/9/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 5/11/30 19
20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20386

Local Registrar's No. 127

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1010 L

2. FULL NAME John Vincent Nash

(a) Residence. No. 509 Pinney Block St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Kathryn Nash

6. DATE OF BIRTH (month, day and year) Jan 21, 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	3	15	1 hrs. or 30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Internal Revenue Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bureau of Internal Revenue

9. BIRTHPLACE (city or town) (State or country) Chapman, Kansas

PARENTS

10. NAME OF FATHER James Nash

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dublin, Ireland

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Fred White
(Address) Boise Idaho

15. Filed 5-6-, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/25, 1930, to 5/6, 1930, that I last saw him alive on 5/6, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. J. Coats, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Shipped 4 May 7, 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 11387

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 3

Primary Registration District No. 1004

Local Registrar's No. 126

(No. 2107 Broadway.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Mrs. Mary N. McKinney.

(a) Residence. No. 2107 Broadway St.
(Usual place of abode.)
Length of residence in city or town where death occured. 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas H. McKinney.

6. DATE OF BIRTH (month, day and year) June 16th 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	6	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Prairie Grove, Ark.

PARENTS

10. NAME OF FATHER William G. Oliver.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Mary E. Smith.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ga.

14. Informant (Address) John W. McKinney. Boise, Idaho.

15. Filed 5-3, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2nd 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from March 15th 1930 to May 2nd 1930
that I last saw h.. alive on April 16th 1930
and that death occurred, on the date stated above, at 7 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Valvular Heart Lesions and High blood pressure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
5/2/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5/4/30, 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 26388

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 125
(No. Salvation Army Rescue Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erma LaVern Miller.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

162

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female,
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 26th 1930

7. AGE Years: 0 Months: 0 Days: 4 If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Ernest Sherman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Ruth Viola Miller.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant (Address) Pearl Allen. Boise, Idaho.

15. Filed 5-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30th 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/26, 1930, to 4-30, 1930
that I last saw her alive on 4-30, 1930
and that death occurred, on the date stated above, at 11:35 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Malnutrition

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Premature Cause unknown

..... (duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? usual

(Signed) Suxomey, M. D.
5/1/30, 19..... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: County Cemetery
Date of Burial: 5-2-30 19

20. Undertaker: Wm. McBratney.
Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 1320

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. 35

(No. 7 Miles West of Boise.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. **FULL NAME** Mrs. Ellen Sevy.

(a) Residence. No. 7 Miles West of Boise. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) November 23rd 1853

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	5	8	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Iowa.
(State or country)

PARENTS

10. NAME OF FATHER Elijah Bartlett.

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Sarah Thorpwood.

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) New Jersey.

14. Informant Mrs. Jessie Patton.
(Address) Ustick, Idaho.

15. Filed ....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1st 1930
(Month) (Day) (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from ----------, 19..., to ----------, 19..., that I last saw h... alive on ----------, 19..., and that death occurred, on the date stated above, at 10:32 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Dropsy. Had been in very poor health for about one year.

No Physician in attendance.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Natural Cause.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? ---

(Signed) Wm McBratney Coroner, M. D.

5/2/30, 19..... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Caldwell
Riverside Cemetery, — Date of Burial 5/3/30 19

20. Undertaker Wm. McBratney. — Address Boise, Idaho.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 156
(No. St. Alphonsus Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. **FULL NAME** Ruth Mary Eiler

(a) Residence. No. 8 mi. No. Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Feb. 21st 1929.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho.

PARENTS

10. NAME OF FATHER Austin Eiler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Edna Betts.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nampa Idaho.

14. Informant (Address) Mr. Austin Eiler, Nampa, Idaho.

15. Filed may 31, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to May 31, 1930, that I last saw her alive on May 30, 1930 and that death occurred, on the date stated above, at 2:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Edema of lungs
Very short (duration), probably after born
CONTRIBUTORY (Secondary) Unresolved double lobar Pneumonia (duration) about 6 days.

18. Where was disease contracted if not at place of death? Nampa Idaho.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy.
(Signed) Harmon Greenlange M. D.
May 31, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 6-1 1930
20. Undertaker: Mrs. Nina M. Talley Address: Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 4824

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 155

(No. 1802 N. 16th street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Charles Thomas Haney. 39

(a) Residence. No. 1802 N. 16th St.
(Usual place of abode.)

Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hattie Haney.

6. DATE OF BIRTH (month, day and year) January 26th 1868

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Manager of Pioneer Tent & Harness
(b) General nature of industry, business, or establishment in which employed (or employer) Company.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Mrs. Hattie Haney. Boise, Idaho.

15. Filed 5-29, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~to~~ ~~, 19~~ ~~that I last saw~~ ~~in~~ ~~alive on~~ ~~, 19~~ about 9:30P m. ~~and that~~ death occurred, on the date stated above, at

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina Pectoris -
Died suddenly sitting in a chair talking to a friend. Complaining of severe pain in Breast before death.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —

(Signed) W. McBratney, Coroner, M. D.
5/29/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain Home, Idaho.	6- , 19 30

20. Undertaker Wm. McBratney. Address Boise, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10822

PLACE OF DEATH
County of Ada
City of Boise.
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 154
(No. 129)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank. M. Breshears.
(a) Residence. No. 918. N. 7 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Breshears.

6. DATE OF BIRTH (month, day and year) July. 16. 1869.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60.	10	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work U. S. Marshall.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Polk County. Missouri.

PARENTS
10. NAME OF FATHER Andrew Jackson Breshears
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Martha Hammack.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant Mrs. Elizabeth Breshears.
(Address) 918. N. 7 Street.

15. Filed 5-26, 1930 W. L. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 21 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-28, 1930, to 5-21, 1930
that I last saw him alive on 5-21, 1930
and that death occurred, on the date stated above, at 9:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Thrombosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Laboratory
(Signed) O. F. Swendsell M. D.
5-24, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: May 23 1930
20. Undertaker: Summers & Krebs — Address: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 153
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.) 92

2. **FULL NAME** Nora Francis Seelye.
(a) Residence. No. 3 Miles South East of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert. F.Seelye.

6. DATE OF BIRTH (month, day and year): December. 1.1901.

7. AGE: 28 Years | Months: 5 | Days: 24. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ada County Idaho.

PARENTS

10. NAME OF FATHER: John. S. Davidson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri.
12. MAIDEN NAME OF MOTHER: Ora. M. Martin.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Michigan.

14. Informant (Address): Albert. F. Seelye. R.D. # 5. Boise, Idaho.

15. Filed 5-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 25, 1930
that I last saw her alive on May 24, 1930
and that death occurred, on the date stated above, at 12 30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Thrombosis and Embolism of Mesenteric Vessels.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Perimeal Varicose Veins
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? P.B. Date of May 18
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) [illegible]
May 26, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Meridian, Idaho. | Date of Burial: May. 28. 1930
20. Undertaker: Summers & Krebs. | Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 26294

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 152
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Deane Gilbert Kester. 101a

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 15th 1930

7. AGE Years 0 Months 0 Days 9 If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Frank J. Kester.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Marna Taylor.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wyo.

14. Informant (Address) Frank J. Kester. Boise, Idaho.

15. Filed 5-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th, 1930, to May 24, 1930
that I last saw him alive on May 24, 1930
and that death occurred, on the date stated above, at 4.45 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia lobar

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Premature birth with Inanition (duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death? Boise, Ida.
Did an operation precede death? yes Date of May 23, 1930
Was there an autopsy? no
What test confirmed diagnosis? Physical Finding
(Signed) Dr. J. M. Downs, M. D.
5/24/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 5/25/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10395

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 151
(No.) 12
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Homer T. Barbour
(a) Residence. No. 408 - S. 18 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Barbour

6. DATE OF BIRTH (month, day and year) March 16-1855

7. AGE Years 75 Months 2 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Black Smith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS
10. NAME OF FATHER James Barbour
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Margaret Sutton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Vermont

14. Informant (Address) Mrs William Matevia 1009 Main St Boise Idaho

15. Filed 5-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 21, 1930
that I last saw him alive on May 21, 1930
and that death occurred, on the date stated above, at 12:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Interstitional
Nephritis
Dout know (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 10/24 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Exam. urine
(Signed) C. S. Allen, M. D.
5/22, 1930 (Address) McCarty Bldg

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial May 23 1930

20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Taylor RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 150
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eileen Elizabeth Morrison.
(a) Residence. No. 1303 Manitou St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

71 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------
6. DATE OF BIRTH (month, day and year) July 3rd 1923.
7. AGE: 6 Years; Months: 10; Days: 17; If LESS than 1 day, ---------- hrs. or ---------- min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In school.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS
10. NAME OF FATHER James Morrison.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.
12. MAIDEN NAME OF MOTHER Cleo Weston.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) Mrs/ Roy Layshure. Boise, Idaho.

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 20th, 1930
that I last saw her alive on May 20th, 1930
and that death occurred, on the date stated above, 11:45A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Meningitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Otitis media with Mastoiditis (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? at house, in Boise
Did an operation precede death? yes Date of May 19th
Was there an autopsy? no
What test confirmed diagnosis? operation & lab tests
(Signed) J. M. Taylor, M. D.
5/20/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery. Date of Burial: 5/23/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 149
(No. 1305 N. 8th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Margaret Williams.
(a) Residence. No. 1305 N. 8th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 37 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: David Williams.
6. DATE OF BIRTH (month, day and year): September 8th 1889
7. AGE: 62 Years, Months: 8, Days: 12. If LESS than 1 day, ---- hrs. or ---- min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Iowa Coutny, Wis.

PARENTS
10. NAME OF FATHER: Chris Powell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales.
12. MAIDEN NAME OF MOTHER: Anna Morris.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Wales.

14. Informant (Address): David Williams. Boise, Idaho.

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to May 20, 1930, that I last saw her alive on May 20, 1930, and that death occurred, on the date stated above, at 8:32 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Primary Interstitial nephritis
(duration) 20 yrs. ? mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 20 yrs. ? mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no. Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physicist Findings
(Signed) Dr. J. M. Dawes, M. D.
5/20/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/22/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Ida

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 148 ✓
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. **FULL NAME** Guy Osborn Flenner.

(a) Residence. No. 415 Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Pearl Flenner.

6. DATE OF BIRTH (month, day and year) November 9th 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Newspaperman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Bluffton, Ohio.
(State or country)

PARENTS

10. NAME OF FATHER J. D. Flenner.
11. BIRTHPLACE OF FATHER (city or town) Etna, Ohio.
(State or Country)
12. MAIDEN NAME OF MOTHER Alice M. Long.
13. BIRTHPLACE OF MOTHER (city or town) Bluffton, Ohio
(State or County)

14. Informant Rex Flenner.
(Address) Boise, Idaho.

15. Filed 5-21, 1930 W. H. McRoberts
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 9:30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATUPE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 4/26/30
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Harold Wilson, M. D.
5/17/30, 19..... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 5/19/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6339

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. V146
(No. 1208 Main Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Zella A. Wardwell.
(a) Residence. No. 1208 Main St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 7th 1892

7. AGE: 38 Years | Months: 0 | Days: 12 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmett, Idaho.

PARENTS
10. NAME OF FATHER W. Wardwell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.
12. MAIDEN NAME OF MOTHER Carrie A. Ray.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wis.

14. Informant (Address) Mrs. Florence Bacon. Boise, Idaho.

15. Filed 5-21 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 — 1930, to May 19 — 1930
that I last saw her alive on May - 19 — 1930
and that death occurred, on the date stated above, at 11 AM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Bright's Disease
Sequale of Influenza.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of ----
Was there an autopsy? No —
What test confirmed diagnosis? ----
(Signed) Anis Budle - Wardwell M. D.
5/20/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Emmett, Idaho. Date of Burial: 5-21-30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20400

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 43
(No. Boise, Idaho. Route #2.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

483

2. **FULL NAME** Henry Etheridge.

(a) Residence. No. Boise, Idaho. Route #2. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Ann Etheridge.

6. DATE OF BIRTH (month, day and year) February 19th 1843

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
87	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London, England.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) William Etheridge. Boise, Idaho. R.#2

15. Filed 5-28, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Ae, 1928, to May 28, 1930
that I last saw h[illegible] alive on May 27, 9 A.M., 1930
and that death occurred, on the date stated above, at 2:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Senile Dementia)

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary embolism
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. M. Halverson, M. D.
5/28/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5/29/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70401

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 42
(No. Barber, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Florence Leora Eells.
(a) Residence. No. Huston, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------
6. DATE OF BIRTH (month, day and year) January 19th 1916
7. AGE Years 14 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS
10. NAME OF FATHER Oliver H. Eells.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota.
12. MAIDEN NAME OF MOTHER Hattie Wallace.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon.

14. Informant (Address) Oliver H. Eells. Huston, Idaho.
15. Filed May 27, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26th 1930 (Month) (Day) 19 (Year)
17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~19~~, to ~~19~~ ~~that I last saw h~~ ~~alive on~~ ~~19~~ ~~and that~~ death occurred, on the date stated above, at 7:40 P.M.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
No. Medical Doctor was in attendance from time of first sickness until death occured. Natural Cause. Probably appendicitis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) No Inquest held. Relatives with patient during all sickness.
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W. McBratney Coroner, M. D.
5/27/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Riverside Cemetery Huston, Idaho. Date of Burial 5/27/30 19
20. Undertaker Wm. McBratney Address Boise, Idaho.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20422

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 40
(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Ethel Ballenger
(a) Residence. No. 1032 Charles Street South Boise
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stephan S. Ballenger

6. DATE OF BIRTH (month, day and year) Oct. 9th 1869

7. AGE Years 60 Months 8 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moroni, Utah

PARENTS
10. NAME OF FATHER Doc Draper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Fanny Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Samuel L Ballenger Boise Ida

15. Filed 5-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to May 20, 1930
that I last saw her alive on May 20, 1930
and that death occurred, on the date stated above, at 1:35 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Double Posterior lower lobes)

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise, Ida.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) Dr. J. M. Downs M. D.
May 21, 1930. (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 5/23 1930

20. Undertaker Schreiber & McCann Address Boise Ida

Dr. Downs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 8

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2004
Primary Registration District No. 2004
Local Registrar's No. 39
(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Theo C. Pankhurst.

(a) Residence. No. Boise, Idaho. St. 740
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
83			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Mining Man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Don't Know.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Pearl Allen, Boise, Idaho

15. Filed 5-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Jan, 1929, to May 15, 1930, that I last saw him alive on May 15, 1930, and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(duration) 2 yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Respiratory
Paralysis (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Brafton M. D.
5/16/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: County Cemetery. Date of Burial: 5/20/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 38
(No. Murphy, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Charles Moss.
(a) Residence. No. Murphy, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Moss.

6. DATE OF BIRTH (month, day and year) July 4th 1856

7. AGE Years 73 Months 9 Days 26 If LESS than 1 day, hrs. or ---- min. ---

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Conn.

PARENTS
10. NAME OF FATHER William Moss.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Mrs. Charles Moss. Murphy, Idaho.

15. Filed 5-7, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15th, 1930, to Apr. 30th, 1930
that I last saw him alive on Apr. 24th, 1930
and that death occurred, on the date stated above, at 5:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of base of rt. lung.
(duration) 0 yrs. 0 mos. 30 ds.
CONTRIBUTORY (Secondary) Carcinoma of Colon.
(duration) 5 yrs. 1 mos. 5 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? History & physical signs.
(Signed) [illegible] M. D.
5/3/30, 19 (Address) Nampa, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 5/3/30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

(Common)

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6665

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 37
(No. 484)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph A Dennison
(a) Residence. No. 3 1/2 miles west of Boise St.
(Usual place of abode.)
Length of residence in city or town where death occured / yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 11, 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant Mrs Cecil Rhodes
(Address) R2 #4 Boise Idaho

15. Filed 5-5-, 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 30, 1930
that I last saw him alive on April 30, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Endocarditis - acute
Acute Brights disease
Chronic Bronchitis
Enlarged Prostate Gland
Inguinal Hernia (duration) 5 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) ~~Enlarged Prostate~~
(duration) 5 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Harris Test
(Signed) of urine J W Cummings M. D.
May 2, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	May 3 1930
20. Undertaker	Address
Summers & Tubbs	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6436

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 36
(No. Boise, Idaho Route #2.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Joe Ratliff

(a) Residence. No. Boise, Idaho Route #2. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Flora Ratliff.

6. DATE OF BIRTH (month, day and year) February 5th 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher and Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10. NAME OF FATHER Robert Ratliff.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Susan Gresham.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tenn.

14. Informant (Address) Mrs. Flora Ratliff. Boise, Idaho. R.#2.

15. Filed 5-5, 1930 (W) J. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2nd 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/1, 1930, to 5-2, 1930 that I last saw him alive on 5/1, 1930 and that death occurred, on the date stated above, at 1 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

3 hrs (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Indigestion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H F Neal, M. D.
5/3/30, 1930 (Address) Meridian, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery.	5-5-30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20407

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 7
Primary Registration District No. 206
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

2. FULL NAME E. Everett Turner

(a) Residence. No. R.D. #3, 2802-No 26, St. 90
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If ~~married, widowed, or divorced~~
HUSBAND of
(or) ~~WIFE~~ of

6. DATE OF BIRTH (month, day and year) Dec 20 - 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt Home Idaho

PARENTS

10. NAME OF FATHER W. J. Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Emma Waller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Bertha B. Ray
(Address) R.D #3. Boise Idaho

15. Filed 6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1926, to May 13, 1930
that I last saw him alive on May 13, 1930
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:
Embolism right cortex with complete left side paresis -
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Endocarditis.
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? physical signs
(Signed) H. P. Rose, M. D.
May 14, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	5/16 1930
20. Undertaker	Address
Fred K. Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70408

PLACE OF DEATH
County of Ada
City of Eagle

Registration District No. 9 & 10
Primary Registration District No. 9 & 10 Local Registrar's No. 1
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

40

2. FULL NAME Sally L. Haynes
(a) Residence. No. 5 Miles North West of Eagle
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widows

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May-11-1854

7. AGE Years 75 Months 11 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Benjamin F Caldwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) G. W. Haynes Eagle Idaho R.D. #1

15. Filed May 8, 1930 Orrie Jackson Eagle Idaho Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1930, to May 6, 1930
that I last saw her alive on May 5, 1930
and that death occurred, on the date stated above, at 5 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mitral regurgation
Chron Bronchitis
Cancer stomach
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer stomach
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. C. Wolfe M.D., M. D.
May 8, 1930 (Address) Nampa, Idaho

19. Place of Burial, Cremation, or Removal Star Cemetery
Date of Burial May 8 1930
20. Undertaker Summers & Kubs
Address Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70409

PLACE OF DEATH

County of Ada.

City of Boise.

CERTIFICATE OF DEATH

Registration District No. 9+10

Primary Registration District No. 9+10 Local Registrar's No. 2

(No. Star, Idaho.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene Henry McGary.

(a) Residence. No. Star, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 14 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mattie McGary.

6. DATE OF BIRTH (month, day and year) February 27th 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	3	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Henry Eugene McGary.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant Mrs. E. H. McGary.
(Address) Star, Idaho.

15. Filed 6/1, 19 30 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3d, 19 30, to May 30, 19 30
that I last saw h— alive on —, 19
and that death occurred, on the date stated above, at 10:35A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Not Sure — Uremalgia Heart

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dead on arrival

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/31/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery.	6/1/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21431

PLACE OF DEATH
County of Adams
City of

Registration District No. 71
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. FULL NAME Infant

(a) Residence. No. Tamarack. Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 1st 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Tamarack. Idaho.

PARENTS

10. NAME OF FATHER Alvin Clemons
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Grace Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) James L. Baker

15. Filed June 17 1930 W. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to June 3rd, 1930, that I last saw him alive on June 3rd, 1930, and that death occurred, on the date stated above, at 3:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

An eight mos. poorly developed infant
Wt vitality enough to live

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) F. A. Benjamin M. D.
June 5th, 1930 (Address) Council, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Winkler Cemetary	June 5 1930
20. Undertaker	Address
F. A. Benjamin M. D.	Council Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 20411

PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

(No Municipal Sanitarium)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 183

100a

2. FULL NAME Levie Monegue

(a) Residence. No. Lava Hot Springs St. Grace Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown

7 AGE: 70 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Provo Utah Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ,,

14 Informant: Mrs. Martha S. Hemmest

(Address) Lava Hot Springs Ida

15 Filed June 1, 1930 Mrs G G Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) - 14. (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 14, 1930, that I last saw him alive on May 14, 1930, and that death occurred, on the date stated above, at 12 5 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Lava

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) G G Fitz, M. D.

June 3, 1930 (Address) Bancroft

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 ~~Place of Burial, Cremation, or~~ Removal: Grace Idaho

Date of Burial: May-15 1930

20. Undertaker: Had none

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70413

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5828
(No. General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Jacob Scheu
(a) Residence. No. Shoshone Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 38 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Section hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Russia

14. Informant (Address) Mrs. Gerhart

15. Filed May 24 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 23, 1930
that I last saw him alive on May 23 1930
and that death occurred, on the date stated above, at 12:50 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
+ Pulmonary Tuberculosis
+ both lungs.
+
+ ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) H. H. Hughart, M. D.
....., 19..... (Address) Pocatello, Idaho

19. Place of Burial, Cremation, or Removal Shoshone Idaho
Date of Burial May 24 1930
20. Undertaker H. L. McHan
Address Poca. Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10414

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5827

90

2. FULL NAME Earl Ralph Cooley

(a) Residence. No. 704 South Tenth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	0	0	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Albert Cooley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Grace Della Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Star, Idaho.

14. Informant Mrs. Rena Bayles
(Address) 704 South Tenth Ave. Poca., Ida.

15. Filed 5/24/30. 19__ J. R. Young Registrar M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23, (Day) 1930. (Year) 19__

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 23, 1930, that I last saw him alive on May 22, 1930, and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Probably due to failure of valve of heart to close.
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) F. S. Miller M. D.
5/23/30. 19__ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho	5/25/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5826
(No. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** James D. Cratta

(a) Residence No. 173 Roosevelt ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 23 yrs. 2 mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14 - 1907

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	2	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER James F Cratta
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Elizabeth A. George
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon.

14. Informant (Address) Mrs. James F Cratta

15. Filed 5/24, 1930 R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-21, 1930, to 5-22, 1930
that I last saw h[illegible] alive on 5-15, 1930
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral stenosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Typical findings

(Signed) [illegible] M. D.
5/23, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Mt View Cemetery — Date of Burial: 5/24 1930
20. Undertaker: H. L. McKern — Address: Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70416

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 1)
Local Registrar's No. 5825

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Hargraves

(a) Residence. No. 726 So. Main St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Thomas Hargraves.

6. DATE OF BIRTH (month, day and year) May 4 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	72		9.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) So Cardiff - Wales

PARENTS

10. NAME OF FATHER James Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.
12. MAIDEN NAME OF MOTHER Elizabeth Chugg.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Mr. Thomas Hargraves.
(Address) 726 - So. Main St.

15. Filed May 15, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1, 1929, to 5-15, 1930
that I last saw her alive on 5-5, 1930
and that death occurred, on the date stated above, at 11.25 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.
5/20, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cemetery	5/18 1930
20. Undertaker	Address
K. L. McFarland	Paca. Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Roberta

DO NOT WRITE IN THIS SPACE
State File No. 20417

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 20
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5824

2. FULL NAME Sallye Nevins

(a) Residence. No. 309 So Johnson St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

44

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jan 13th 1886

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 44, Months 4, Days 3. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mt Home Ida

PARENTS

10. NAME OF FATHER: W. S. Colloway
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn
12. MAIDEN NAME OF MOTHER: Ida Gaforth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: J. V. Nevins
(Address) Pocatello Ida.

15. Filed 5-18, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1928, to May 16, 1930
that I last saw her alive on May 16, 1930
and that death occurred, on the date stated above, at 10.30 a.m.
The CAUSE OF DEATH* was as follows: Carcinoma uterus & bladder.
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) [signature] M. D.
5/16, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain Home Ida — Date of Burial: 5/18 19

20. Undertaker: Schumacher & Beasley — Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1418

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216-1
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5823

92

2. FULL NAME Hyrum A. Curtis

(a) Residence. No. 254 Taft Avenue St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Chlois Hancock

6. DATE OF BIRTH (month, day and year) May 11, 1880.

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	0	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shopman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country) Payson, Utah.

PARENTS

10. NAME OF FATHER Joseph Curtis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Payson, Utah.

12. MAIDEN NAME OF MOTHER Tabitha Richardson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia.

14. Informant Mrs. Hyrum A. Curtis
(Address) 254 Taft Ave. Pocatello, Idaho.

15. Filed 5/17/30., 19__. J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 14, 1930
that I last saw h[illegible] alive on May 14, 1930
and that death occurred, on the date stated above, at 7 30 m.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of —
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) W. W. Brothers, M. D.
5-15-30, 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Firth, Idaho.	5/18/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20419

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5822

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 455 N. Arthur)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Fowler 90

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21 - 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	6	22	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) R.R. Engineer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John Fowler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Gyson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Miriam Fowler
(Address) Pocatello Idaho

15. Filed 5-15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1928, to May 13, 1930
that I last saw h[illegible] alive on May 12, 1930
and that death occurred, on the date stated above, at 6 O. m.
The CAUSE OF DEATH* was as follows:
Cardio-renal failure
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) [signature] M. D.
5/14, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
LaCrosse Wis	5/19 1930
20. Undertaker	Address
Schumacher & Beady	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6420

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No.
Primary Registration District No.
(No. 255 So. Garfield)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Mabel L. Tuttle Tupper
(a) Residence. No. 255 So. Garfield St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 1, 1866

7. AGE Years: 64 Months: — Days: 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Maine

PARENTS
10. NAME OF FATHER: Charles Tuttle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Susan D.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant: Mabel Tupper Peake
(Address) 1121 1st Ave. Salt Lake City

15. Filed May 15, 1930 J R Young Registrar M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to May 13, 1930
that I last saw her alive on May 13, 1930
and that death occurred, on the date stated above, at 11:25 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardio Renal
Disease (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) C R Groom, M. D.
5/15, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho
Date of Burial: May 16 1930

20. Undertaker: McHan H. L.
Address: Pocatello Ida

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20421

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5819
(No. Lynn Bros. Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Maranda E Kafe.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 10 1854

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	0	2.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Jerry Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs E Brown
(Address) Pocatello Idaho

15. Filed 5-14-, 1930 C R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to May 12, 1930
that I last saw her alive on May 12, 1930
and that death occurred, on the date stated above, at 6 8 0 9 m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) J H Lynn, M. D.
5/13/30 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Encampment Wyo.	May 16 1930
20. Undertaker W. F. McHan	Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20422

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 519 N Garfield)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5819

90

2. FULL NAME Reese. E Clawson
(a) Residence. No. 519 N Garfield St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 4th 1872

7. AGE: Years 58, Months 1, Days 22. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Traveling Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Clawson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Jack Lyness
(Address) Pocatello Idaho

15. Filed 5/10/30, 19... J R Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1935, to May 8, 1935
that I last saw him alive on May 8, 1935
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Cardio Renal
Disease.
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C D Groom M. D.
5/9/, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida — Date of Burial: 5/11 1930

20. Undertaker: Schumacher & Beasley — Address: Pocatello

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20423

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5817

(No. Lynn Bros. Hospital Poca.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ina Valier Gillies

(a) Residence. No. 706 North Eighth Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 23, 1912.

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	3	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) At Home & At School

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho.

PARENTS

10. NAME OF FATHER David A. Gillies

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER Margaret Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City, Utah.

14. Informant David A. Gillies

(Address) 706 North 8th., Ave. Poca., Ida.

15. Filed 5/10/30., 19.... J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 8, 1930
that I last saw her alive on May 6 - 1930
and that death occurred, on the date stated above, at 6.55 P m.

The CAUSE OF DEATH* was as follows:

Basal Skull Fracture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. 1 hr ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. R. Young M. D.

5/10/30., 19.... (Address) Poca., Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	5/11/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7042 4

Registration District No.
Primary Registration District No.
Local Registrar's No. 5816

PLACE OF DEATH

County of Bonneck
City of Pocatello
(No. 658 So Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Virginia Leone Shumaker

(a) Residence. No. 658 So Hayes St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6. DATE OF BIRTH (month, day and year) July 18th 1918

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
11	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER F P Shumaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Hazel Shumaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Frank P Shumaker
(Address) Pocatello Idaho

15. Filed 5/7, 1930 J H Powell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1930, to May 5, 1930
that I last saw her alive on May 5, 1930
and that death occurred, on the date stated above, at 6 45 a.m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart
(duration) 1 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Phy findings
(Signed) J H Thomas M. D.
5/6/30, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	5-7 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 10425

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5838
(No. none)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James A. Jones

(a) Residence. No. 725-W Fremont St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Lana Jones

6. DATE OF BIRTH (month, day and year) Nov 1 1848

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
Eighty Two	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Huntington N. Y.

PARENTS

10. NAME OF FATHER James A. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y. State
12. MAIDEN NAME OF MOTHER Frances A.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y. State

14. Informant (Address) Mrs L. Jones

15. Filed 6-9, 1930 J. R. Jones Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-2, 1930, to June 6, 1930
that I last saw h.m alive on June 6, 1930
and that death occurred, on the date stated above, at 6 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Intestines

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) W. W. Brothers, M. D.
6-8, 1930. (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Mt View Cemetery — Date of Burial: June 8 1930
20. Undertaker: H. L. McHan. — Address: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20426

PLACE OF DEATH
County of Bonneck
City of Pocatello

Registration District No. 28
Primary Registration District No. 3161
(No. 605 South 6th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5837

48B

2. FULL NAME John Thomas Kane

(a) Residence No. 605 South 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23rd 1866

7. AGE Years	Months	Days	If LESS than 1 day,
63	7	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Railway Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilkesbarre Pa

PARENTS

10. NAME OF FATHER James Kane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Budgett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs John T Kane
(Address) 605 So 6th Pocatello Idaho

15. Filed 6-9, 1930 J. R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1929 to June 6 1930
that I last saw h[illegible] alive on June 2 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension and nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) [signature] M. D.
6/7, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	6-10th 1930
20. Undertaker	Address
Schumacher & Beasley	City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 0428

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5835
(No. Poc Gen Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

111 B

2. FULL NAME Grace Benolkin
(a) Residence. No. 54 E. E. Holiday St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. ~~mos.~~ ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Benolkin
6. DATE OF BIRTH (month, day and year) 21 April 1880
7. AGE Years 50 Months 1 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Atchine Kansas

PARENTS
10. NAME OF FATHER Levi Allen
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Rodillia Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) John G. Benolkin
15. Filed June 5, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 3, 1930
that I last saw her alive on June 3, 1930
and that death occurred, on the date stated above, at 11 10 a m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Perforated duodenal ulcer
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
6-5, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Pocatello Idaho
Date of Burial June 6 1930
20. Undertaker H. L. McHan
Address Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20429

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5834

107

2. FULL NAME James Oscar Minshew

(a) Residence. No. 416 South Ninth Ave. Poca., Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Maggie Mooring

6. DATE OF BIRTH (month, day and year) January 28, 1872.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	58	4	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Eureka, North Carolina.

PARENTS

10. NAME OF FATHER: John Vick Minshew
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Eureka, North Carolina.
12. MAIDEN NAME OF MOTHER: Martha Overman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Eureka, North Carolina.

14. Informant: Mrs. Alden Houde
(Address) 416 South Ninth Ave. Poca., Ida.

15. Filed 6/5/30., 19____ J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 3, 1930
that I last saw h[e] alive on June 3 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Edema of Lungs
(duration) ____ yrs. ____ mos. 1 ds.
CONTRIBUTORY (Secondary) Bronchial asthma
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? North Carolina
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____

(Signed) [illegible], M. D.
6/5/30., 19____ (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	6/6/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

Roberts

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20430

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5833

90

2. FULL NAME Annie Mary Blakely
(a) Residence. No. 245 N 9th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. A. Blakely

6. DATE OF BIRTH (month, day and year): Oct 20 - 1886

7. AGE: 43 — Years [illegible] Months 7 Days 12 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Cheyene Wyo

PARENTS
10. NAME OF FATHER: William Elliott
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: W A Blakely
(Address) Pocatello Idaho

15. Filed 6 - 3, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 - 1, 1930, to 6 - 2, 1930
that I last saw he alive on 6 - 1, 1930
and that death occurred, on the date stated above, at 4.20 A.m.
The CAUSE OF DEATH* was as follows:
Cardio-renal disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Myocarditis
Endocarditis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
6/4, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake Utah
Date of Burial: 6-5- 1930

20. Undertaker: Schumacher & Beasley
Address: Pocatello

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 50432

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5831

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME Ada Chandler Morgan

(a) Residence. No. 235 West Sherman Ave. St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of John Morgan

6. DATE OF BIRTH (month, day and year): March 1, 1904.

7. AGE: Years 26, Months 3, Days 0. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Salt Lake City, Utah.

PARENTS

10. NAME OF FATHER: Charles F. Chandler

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER: Julia Dean Young

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City, Utah.

14. Informant: Mrs. Julia Y. Chandler
(Address) Idaho Falls, Idaho.

15. Filed 6/5/30., 19__ J R Young Registrar MD.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 1, 1930. 19__
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ___, 19__, to ___, 19__

that I last saw h___ alive on ___, 19__

and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:
Crushing abdominal injury caused by auto accident
Accidental
~~Just~~ Driving by Clyde Fisher
(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ___

Did an operation precede death? ___ Date of ___

Was there an autopsy? ___

What test confirmed diagnosis? ___

(Signed) Arthur W Hall, M. D.

6/5/30., 19__ (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.
Date of Burial: 6/5/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Dr. Mathews

RECEIVED JUN 12 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2461

(No. 1042 N. Garfield)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 20433

Local Registrar's No. 5838

48B

2. FULL NAME Joseph A. Dugalls

(a) Residence. No. 1042 N. Garfield St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year): Mar 7 - 1850

7. AGE: Years 80 | Months 2 | Days 24 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired C.S.L. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: John Dugalls

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Alexander

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Mrs Josephine Young

(Address): Pocatello Idaho

15. Filed 6-3-, 1930 J R Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 1st 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to June 1, 1930

that I last saw him alive on June 1, 1930

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

[redacted]

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile insanity

(duration) 3 yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Brothers M. D.

6-4, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: June 4 1930

20. Undertaker: Schumacher & Beasley — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20424

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 63
Primary Registration District No.
Local Registrar's No. 1 B O

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101 a

2. FULL NAME Ella Anna Scheidegger Curless

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. 5 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eugene Daniel Curless
6. DATE OF BIRTH (month, day and year): Dec 20, 1897
7. AGE: Years 32 | Months 5 | Days 11 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Paris Idaho.

PARENTS
10. NAME OF FATHER: John Scheidegger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland
12. MAIDEN NAME OF MOTHER: Eliza Sutter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: E. Curless
(Address)

15. Filed 6-2, 1930 Mrs. J. A. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 31, 1930
that I last saw her alive on May 31, 1930
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH*, was as follows:
Pneumonia. Bilateral Lobular
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Pneumococcus dulbecco
Temp: 104.
(Signed) Spencer H. Rich M. D.
June 1, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: June 2 1930
20. Undertaker: D. S. Price — Address: Paris Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 11 1930

PLACE OF DEATH

County of Bear Lake

City of St. Charles

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 55

Primary Registration District No. 2134

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 10435

Local Registrar's No. 3

91B

2. FULL NAME Elizabeth Stock Rich.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hyrum S. Rich

6. DATE OF BIRTH (month, day and year): Sept. 21. 1848

7. AGE: Years 81 Months 7 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Port Elizabeth Africa

PARENTS

10. NAME OF FATHER: John Stock

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Port-Elizabeth Africa England

12. MAIDEN NAME OF MOTHER: J Adams

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see her , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Arterial Hypertension.
Acute Cardiac Dilatation 45 Min. duration)
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Hypertension
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No. Ezra Rich M.D. tested B.P. with Sphygmomanometer
What test confirmed diagnosis?
(Signed) Spencer H. Rich, M. D.
April 21 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Charles Idaho — Date of Burial: April 22 1930

20. Undertaker: None — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20436

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

111a

2. FULL NAME Adam Campbell

(a) Residence. No. 128 - 3rd St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Ella Campbell

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 71, Months 10, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Groceries and Confectionary
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Eau Claire Wis

PARENTS

10. NAME OF FATHER: Wm Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Mary Fennessy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Ella Campbell
(Address) St Maries

15. Filed 6 - 7, 1930 Walter Roberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 31, 1930
that I last saw him alive on May 31, 1930
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Gastric ulcer with hemorrhage
(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) Prostatic Hypertrophy and Multiple Arthritis (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C A Robins, M. D.
6/4, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: June 3 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20437

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 17

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Myrtle A Bryan
(a) Residence. No. Caterpell Mont St. Kalispell, Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Bryan

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 39 Months 7 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Homewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wis

PARENTS

10. NAME OF FATHER: Thomas Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pen
12. MAIDEN NAME OF MOTHER: Sarah
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Mrs E G Martin
(Address) St Maries Ida

15. Filed 6-1, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 23, 1930
that I last saw her alive on May 23, 1930
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Veradale Wash
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) D Clarinwall, M. D.
5/23, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries
Date of Burial: May 26 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11433

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2nd 9

Local Registrar's No. 16

(No. 90 Hayland
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gus Helmon

(a) Residence. No. ____ St. Lotus, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Helmon

6. DATE OF BIRTH (month, day and year):

7. AGE: Years: 65 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: R.R. Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Blackwell Lbr Co.

9. BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10. NAME OF FATHER: John Helmon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Finland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Joseph Johnson
(Address): Wayland Ida

15. Filed 6-1, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h— alive on ____, 19__
and that death occurred, on the date stated above, at 8a m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G L Eyke, M. D.
5/17, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	May 19 1930
20. Undertaker	Address
Geo E Mitchell	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70439

PLACE OF DEATH

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 15

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Francis Gardner

(a) Residence. No. ..... St. Fernwood, Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	7	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Harrison Ida
(State or country)

PARENTS

10. NAME OF FATHER Ray Gardner

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Minn

12. MAIDEN NAME OF MOTHER Bertha Osburn

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mo

14. Informant Mrs Ray Gardner
(Address) Clarkia Ida

15. Filed 6-1, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1928, to May 9, 1930

that I last saw him alive on May 9, 1930

and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Past operative shock - following transplantation of ureters

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Fracture pelvis - cicatrical transformation of bladder - due to infection

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 8-1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D E Cornwall, M. D.

....., 19.... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries Ida	May 11 1930

20. Undertaker	Address
Geo E Maries Ida	St Maries

RECEIVED JUN 7 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70440

1 PLACE OF DEATH
County Bennock State Idaho Registered No.
Township or Village Dr Sunt Idy or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marie Bernita Lasort

161a

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 29-30

7 AGE Years Months Days 2 If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Dr Sunt Idy
(State or country)

PARENTS
10 NAME OF FATHER Geo Lasort
11 BIRTHPLACE OF FATHER (city or town) Mont.
(State or country)
12 MAIDEN NAME OF MOTHER Clotilda Luke
13 BIRTHPLACE OF MOTHER (city or town) Dr Sunt
(State or country) Idaho

14 Informant George Lasort
(Address) Desmet, Idaho

15 Filed June 1, 1930 John Rost
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to May 31, 1930, that I last saw her alive on May 29, 1930, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:
Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical
(Signed) J A Nelson, M. D.
5/31/30 (Address) Dekon Ary

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Desmet, Idaho
DATE OF BURIAL June 1, 1930

20 UNDERTAKER George Lasort
ADDRESS Desmet, Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 98

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10441

PLACE OF DEATH
County of Bingham
City of Blac foot
Registration District No. 21
Primary Registration District No. 2144
Local Registrar's No. 70
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME NELLIE OSBORN

(a) Residence. No. ..... St. HAGERMAN, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Edward Osborn

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Isaac N Gresham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mylissa Triplet
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant GRACE A Clippinger, R.N.
(Address) Blackfoot, Ida.

15. Filed May 31, 1930 Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29th, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 28th 1930, 19 AM, to May 29th 1930, 19
that I last saw her alive on May 29th, 1930, 19
and that death occurred, on the date stated above, at 8:52 P m.

The CAUSE OF DEATH* was as follows:
Exhaustion following acute Melancholy

(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) Operation for removal of Imroved gland
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Hagerman Ida.
Did an operation precede death? Yes Date of April 28 1930
Was there an autopsy? No
What test confirmed diagnosis? Doctors Exam.
(Signed) W. E. Petrie, M. D.
(Address) Blackfoot
May 31st, 1930 Acting Supt. Asylum.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cemetary	May 31 1930
20. Undertaker Acting. F. A. GOLDSWORTHY	Address BLACKFOOT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70442

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 69

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

171

2. FULL NAME LEON D EVANS

(a) Residence. No. ..... St. Pocatello
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE

4. COLOR OR RACE: WHITE

5. Single, Married, Widowed, or Divorced (write the word): MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Hazel Evans

6. DATE OF BIRTH (month, day and year)

7. AGE: 31 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Timekeeper R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad

(c) Name of employer: Union Pacific RR

9. BIRTHPLACE (city or town) (State or country): Malad Idaho

PARENTS

10. NAME OF FATHER: Evans Evans

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Peabody

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Grace A Clippinger R.N.
(Address) Blackfoot, Ida.

15. Filed May 28 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: MAY 28,1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14th 1930, 19..., to May 28,1930, 19...
that I last saw him alive on May 28th 1930, 19...
and that death occurred, on the date stated above, at 2.15P m.

The CAUSE OF DEATH* was as follows:

Septicemia from wound of throat with suicidal intent

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

14 days (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.

May 28th, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho | Date of Burial: 5 30 1930

20. Undertaker: Schumacher & Beasley | Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20443

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 12
Primary Registration District No. 2121
Local Registrar's No. 68
(No.) 194
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore Foster Harder

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 19. 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electric Lineman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Teton City, Ida.

PARENTS

10. NAME OF FATHER August Harder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Isebell Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant E. J. Harder
(Address) St. Anthony, Ida.

15. Filed May 26 1930. Mrs Walter E. Petrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 25, 1930
that I last saw h[illegible] above. Probably dead when arrived could not resuscitate him
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental Electrucution
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. A. Beck, M. D.
5/26, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Anthony, Ida.	19

20. Undertaker	Address
E. J. Rusk	Blackfoot

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20444

PLACE OF DEATH
County of Bingham
City of Blackfoot.
Registration District No. 12
Primary Registration District No. 1007
(No. Blackfoot General Hospital)
Local Registrar's No. 67
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Shigeyoshi Tanikuni
(a) Residence. No. 340 N. E. Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 15 - 1920

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	9	9	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho

PARENTS

10. NAME OF FATHER J. Tanikuni
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Some Okano
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant K. Nishida
(Address) Blackfoot Idaho

15. Filed May 23, 1930 Mrs Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 21, 1930, that I last saw him alive on May 21, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ____ yrs. ____ mos. 3 ds.
CONTRIBUTORY (Secondary) Gangrenous appendix
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of May 5th 1930
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. W. Mitchell, M. D.
May 24 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello — Date of Burial: May 28 1930
20. Undertaker: E J Funk — Address: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20445

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. (No number))
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 66

108

2. FULL NAME Reed Parker Clark

(a) Residence. No. West Center Street. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 25. 1929.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER: Geo. H. Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho.
~~Louise~~
12. MAIDEN NAME OF MOTHER: Louise Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Geo H. Clark
(Address) Blackfoot. Ida.

15. Filed May 21, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. 20. 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 20, 1930
that I last saw him alive on May 18, 1930
and that death occurred, on the date stated above, at 5:00 a m.
The CAUSE OF DEATH* was as follows:

Paralysis of muscles of swallowing
(duration) \ yrs. \ mos. 5 ds.

CONTRIBUTORY (Secondary): Pneumonia
(duration) \ yrs. \ mos. 15 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
5/20, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cem. Date of Burial: May. 21. 30. 19

20. Undertaker: Modern Mortuary, Address: Blackfoot. Ida.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20446

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 65

(No. SOUTH IDAHO INSANE ASYLUM)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME JOHN HENRY MILLER

74A

(a) Residence. No. ..... St. Boise

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	---

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Fred Hayes Att.

(Address) Blackfoot, Ida.

15. Filed May 15, 1930 Mrs Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1927, to May 15th 1930

that I last saw him alive on May 15th, 1930

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

CEREBRAL HEMORRHAGE

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams M. D.

May 15th, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Asylum Cemetary	19

20. Undertaker Acting Address

Marion Clark Blackfoot Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7047

PLACE OF DEATH

County of Bannock
City of Blackfoot

Registration District No. 12
Primary Registration District No. 1007
(No. 220 S. Stevenson)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

9/13

2. FULL NAME Lucile M. Moore

(a) Residence. No. 220 So. Stevenson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 21 1842

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88		21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Chas. P. Baldwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John B. McHoust
(Address) Blackfoot Idaho

15. Filed May 16, 1930 Mrs. Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15, 1930, to May 14, 1930
that I last saw her alive on May 14, 1930
and that death occurred, on the date stated above, at 12:00 noon m.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(duration) Several mos. years

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Beck M. D.
5/16, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Groundlay Cemetery	
20. Undertaker E J Peck	Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10430

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 12
Primary Registration District No. 2194
Local Registrar's No. 60

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Buddy V. Eaton
(a) Residence. No. ..... St. Shelley, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 29, 1929
7. AGE Years Months 9 Days 5 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Shelley, Idaho

PARENTS
10. NAME OF FATHER J. E. Eaton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vernal Utah
12. MAIDEN NAME OF MOTHER Alice Bertha Starkie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vernal Utah

14. Informant J. E. Eaton
(Address) Shelley Idaho
15. Filed May 6, 1930 Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-15-, 1930, to 5-4-, 1930
that I last saw him alive on 5-3-, 1930
and that death occurred, on the date stated above, at 12:30A m.
The CAUSE OF DEATH* was as follows:
Rachitis & anemia.
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 4 ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Edwin Cutler, M. D.
5-5-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley — Date of Burial May 6 1930
20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70451

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 59
(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Jane Taylor.
(a) Residence. No. Blackfoot R. R. 1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. H. Taylor
6. DATE OF BIRTH (month, day and year): June 23, 1851
7. AGE: Years 78 | Months 10 | Days 11 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Mount Airy North Carolina

PARENTS
10. NAME OF FATHER: William V. Marsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country):
12. MAIDEN NAME OF MOTHER: Susanah Dunnagan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: C. H. Taylor
(Address): Blackfoot R. R. #1
15. Filed May 5, 1930 Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 3, 1930
that I last saw her alive on May 3, 1930
and that death occurred, on the date stated above, at 3:30 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. W. Beck, M. D.
May 5, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lone City Cemetery — Date of Burial: May 6 1930
20. Undertaker: E. J. Funk — Address: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

PLACE OF DEATH

County of Blaine

City of Gannett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 57

Primary Registration District No. 2022

(No. 129 Wright)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 20453

Local Registrar's No. 16

2. FULL NAME Wm Edmiston

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	7		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ephrim Utah

PARENTS

10. NAME OF FATHER John Edmiston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pittsburg Penn.

12. MAIDEN NAME OF MOTHER Mary Snow

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant M R Edmiston

(Address) Gannett Idaho

15. Filed 6/1, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1, 1929, to 4-22, 1930

that I last saw him alive on 4-1, 1930

and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. H. Wright M. D.

4/23, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gannett, Ida	April 25 1930
20. Undertaker	**Address**
Harris & Cenvo	Hailey Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70454

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. Hailey clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

101 B

2. FULL NAME Dorthy Albers Jensen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Jensen

6. DATE OF BIRTH (month, day and year): July 28-1894

7. AGE: Years 35, Months 8, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Sterno Nebraska

PARENTS

10. NAME OF FATHER: M. L. Albers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Lydia Krueger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Arthur M Jensen
(Address): Hailey Idaho

15. Filed 6-1, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) - 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-6, 1930, to 4-19, 1930
that I last saw her alive on 4-19, 1930
and that death occurred, on the date stated above, at 5.15 a.m.
The CAUSE OF DEATH* was as follows:
(Double) hypostatic Pneumonia
Hemolytic Type
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Ruptured Gangrenous Pus
appendix (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 4/9-30
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) E W Fox, M. D.
4/19, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City Ut
Date of Burial: 19

20. Undertaker: Harris & Amos
Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20455

PLACE OF DEATH

County of Blaine

City of Hailey

Registration District No. 57

Primary Registration District No. 2022

Local Registrar's No. 14

(No. Hailey Clinical Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Ida Mary Graham

(a) Residence. No. ..... St. Fox

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 22 - 1865

7. AGE: Years 64, Months 8, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: X

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Portland - Ore -

PARENTS

10. NAME OF FATHER: Louie Bourgeois

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary O'Shea

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Mrs Cynthia Davy

(Address): Hailey - Ida.

15. Filed 6 - 1, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/4, 1930, to 4/5, 1930

that I last saw her alive on 4/5, 1930

and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Garnett, Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

4/5, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho — Date of Burial: April 7 1930

20. Undertaker: Harris & Amos E-244 — Address: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20456

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. 490 Wright)
Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Higgo

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Apr 20 - 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	1	1	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED X

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Llanidloes - Wales

PARENTS

10. NAME OF FATHER Evans.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Mary Brown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Margaret Higgs Henry.
(Address) Bellevue - Ida.

15. Filed 6 - 1, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 - 21, 1929 to 5 - 21, 1930
that I last saw her alive on 1 - 23, 1930
and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R. H. Wright - M. D.
5 - 22, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue - Ida	May 23 1930
20. Undertaker	**Address**
Harvey Amos	Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70457

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. Hailey Clinical)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

48B

2. FULL NAME William Manuel

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 5 - 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	1	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Thomas Manuel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Jane —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Self. Hospital Record
(Address) E. W. Ft. Hailey, Ida

15. Filed 6-1, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 15, 1930
that I last saw him alive on May 15, 1930
and that death occurred, on the date stated above, at 10.40 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Carey, Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Ft, M. D.
5/16, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey City Cemetary
Date of Burial: May 18 1930

20. Undertaker: Harris & Amos
Address: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 10458

Local Registrar's No. 18

PLACE OF DEATH

County of Blaine

City of Bradford

Registration District No. 57

Primary Registration District No. 2022

(No. 44)

(If death occurred in a hospital or institution, give its name instead of street and number.) wright

2. FULL NAME Sarah Campbell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Feb 27 - 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	2	27	

8. OCCUPATION OF DECEASED X

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) North Wales.

PARENTS

10. NAME OF FATHER John Roberts.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales -

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales -

14. Informant Jessie M Anderson
(Address) Hailey Ida.

15. Filed 6 - 1, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 - 1, 1930, to 5 - 14, 1930 that I last saw her alive on 5 - 14, 1930 and that death occurred, on the date stated above, at 12 12 m.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of ✓

Was there an autopsy? No. What test confirmed diagnosis? clinical & X Ray

(Signed) R. H. Wright - M. D.

5 - 15, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Idaho	May 16 1930
20. Undertaker	Address
Harris & Cannos	Hailey

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20459

Local Registrar's No. 17

Registration District No. 57
Primary Registration District No. 2022

PLACE OF DEATH

County of Blaine
City of Hailey

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pearl Cynthia Davy

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90 Fox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 7th 1920

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	6	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Hailey Ida.

PARENTS

10. NAME OF FATHER Bryan Davy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hailey Ida.
12. MAIDEN NAME OF MOTHER Cynthia Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hailey - Ida.

14. Informant Bryan Davy
(Address) Hailey - Ida.

15. Filed 6-1, 1930 T. F. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 7, 1930
that I last saw h. alive on May 7, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. W. Fox, M. D.
May 8, 1930 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hailey Cemetery	May. 9 1930
20. Undertaker	Address
Harris & Sons	Hailey - Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Evans

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20460

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 25
Primary Registration District No. 2185
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

47

2. FULL NAME Nancy Ellen Apperson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of J. D. Apperson

6. DATE OF BIRTH (month, day and year) Sept. 4, 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	65	8	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eugene Oregon.

PARENTS

10. NAME OF FATHER William W. Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Celia Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant J. D. Apperson
(Address) Sandpoint Idaho.

15. Filed May 12, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE ~~OF DEATH~~ May (Month) 10, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 20, 1930, to May 10th, 1930
that I last saw her alive on February 20, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) F. B. Evans M. D.
May 12, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River, Idaho.	May 12, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20491

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 8
Primary Registration District No. 2157

Local Registrar's No. 6

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME John Notsbe

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 13, 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logging Supt.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Notsbe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Sorlensky

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant James Campbell
(Address) Hope, Idaho

15. Filed May 31, 1930 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 29, 1930
that I last saw him alive on May 29, 1930
and that death occurred, on the date stated above, at 5:50 P. m.
The CAUSE OF DEATH* was as follows:
Dilatation of the heart.
Chronic.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + X Ray
(Signed) Floyd Freeman, M. D.
May 30, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Seattle, Wash.	

20. Undertaker Moon Mortuary Address Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20452

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2155
(No. Sandpoint Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

90

2. FULL NAME Arne Arthur Takala

(a) Residence. No. Cabinet, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 26, 1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	14	7	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marietown, Mont.

PARENTS

10. NAME OF FATHER John Jarvi

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Matt Takala
(Address) Cabinet, Ida

15. Filed May 29, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 28, 1930
that I last saw him alive on May 27, 1930
and that death occurred, on the date stated above, at 2:20 A.m.

The CAUSE OF DEATH* was as follows:
1. Aortic regurgitation duration unknown
2. Lymphadenitis, Chronic
(duration) several yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Cabinet, Idaho
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. C. Staechouse, M. D.
5-29, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest — Date of Burial: June 1, 1930
20. Undertaker: Moon Mortuary — Address: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 26483

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 45
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME Mrs Rosetta Foster

(a) Residence. No. Sandpoint (Rural, Dover Rd.)
(Usual place of abode)
Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ira J Foster

6. DATE OF BIRTH (month, day and year) Nov 19 1839

7. AGE	Years	Months	Days	If LESS than 1 day,
	90	6	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Landesberre
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Ira A Foster
(Address) Sandpoint Idaho

15. Filed May 31, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1928, to May 28, 1930
that I last saw her alive on May 27, 1930
and that death occurred, on the date stated above, at 9:35 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Wm F. Tyler, M. D.
May 29, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	May 31 1930
20. Undertaker Turnbull & Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70434

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

90

2. FULL NAME C. I. Barrett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: Years 71 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: L. H. Moon
(Address): Sandpoint, Idaho

15. Filed May 22, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~ May (Month) 19th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to May 19, 1930
that I last saw him alive on May 18, 1930
and that death occurred, on the date stated above, at 6:20 A.m.
The CAUSE OF DEATH* was as follows:
Cardio-vascular-renal with anasarca
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary): Lobar Pneumonia
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) P. B. Evans, M. D.
5-22, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery | Date of Burial: May 22, 1930

20. Undertaker: Moon Mortuary | Address: Sandpoint, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20435

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 43

(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Everett Henry Heath

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 8 1929

7. AGE Years: 0 Months: 11 Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sagle Ida

PARENTS

10. NAME OF FATHER Gilbert Heath

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Neb

12. MAIDEN NAME OF MOTHER May Lisle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb

14. Informant Gilbert Heath
(Address) Dover Ida

15. Filed May 17, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) ~~16~~ 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13th, 1930, to May 16, 1930

that I last saw him alive on May 16, 1930

and that death occurred, on the date stated above, at 6:10 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. D. Grant, M. D.

May 17, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: 5/18/1930

20. Undertaker: Turnbull Co — Address: Sandpoint.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70466

Local Registrar's No. 42

Registration District No. 78
Primary Registration District No. 2155

PLACE OF DEATH
County of Bonner
City of Sandpoint
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie May Rogers.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chester A. Rogers.

6. DATE OF BIRTH (month, day and year) April 22, 1879.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51		19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Thos. E. Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Emily Sidle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Chester A. Rogers
(Address) Sandpoint, Idaho.

15. Filed May 14, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-2, 1930, to May-8, 1930
that I last saw her alive on May-8, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Influenza

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Edgar G. Wendle M. D.
5-13, 1930 Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	May 14, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 41

(No. I223 W Pine st)

(If death occurred in a hospital or institution, give its name instead of street and number.)

126

2. FULL NAME Mrs. Agnes M North

(a) Residence. No. I223 Pine St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E.H.North

6. DATE OF BIRTH (month, day and year) Feb 15 1887

7. AGE: Years 43, Months 2, Days 19. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER Thos Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E.H.North
(Address) I223 Pine St

15. Filed May 6, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to May 4, 1930 that I last saw her alive on May 4, 1930 and that death occurred, on the date stated above, at 11:45P m.

The CAUSE OF DEATH* was as follows: Peritonitis, Tubercular

Not known prob 1 mo (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Stackhouse, M. D.

May 5, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: May 6 1930

20. Undertaker: Turnbull Co — Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. D 1439

PLACE OF DEATH

County of Bonnveville

City of Idaho Falls, Ida.

Registration District No. 73

Primary Registration District No. 210-0

Local Registrar's No. 1-9

(No. 100 A)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Edwards,

(a) Residence. No. ..... St. Lincoln, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 21, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		12	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho.

PARENTS

10. NAME OF FATHER Vernon B. Edwards.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minckcreek Idaho.

12. MAIDEN NAME OF MOTHER Harriet E. Barrington,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Riverdale, Idaho.

14. Informant Vernon B. Edwards,

(Address) Idaho Falls, Rt. #1.

15. Filed Apr 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to April 2, 1930
that I last saw him alive on Apr 2, 1930
and that death occurred, on the date stated above, at 7 45 m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Double Club Palate Hare Lip

(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

4/2, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton,	April 4 1930
20. Undertaker Jake A. Ward	Address Idaho Falls

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70470

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No. 73
Primary Registration District No. 214-0
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. V-4

101B

2. FULL NAME John Browning
(a) Residence. No. Iona, Idaho St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 5, 1862

7. AGE: Years 67 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden, Utah

PARENTS
10. NAME OF FATHER: David H. Browning
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Jane Elizabeth Garner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Mrs. Mattie Irwin
(Address) Idaho Falls, Idaho

15. Filed Apr 2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6 p m.
The CAUSE OF DEATH* was as follows:
Pneumonia
No medical attendance.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
April 2, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Annis, Idaho — Date of Burial: April 2 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10471

PLACE OF DEATH
County of Bonneville
City of Idaho Falls Ida.

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 57

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME .....

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 4-12-30

7. AGE Years Months Days If LESS than 1 day, 14 hrs. or 55 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) L. D. S. Hospital Idaho Falls, Ida

PARENTS

10. NAME OF FATHER Joseph Perial Cox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelly Ida
12. MAIDEN NAME OF MOTHER Eva Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ovid Idaho

14. Informant Dr Edwin Cutler
(Address) Shelly Idaho

15. Filed Apr 18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-~~10~~ 12, 1930, to 4-13, 1930
that I last saw her alive on 4-13, 1930
and that death occurred, on the date stated above, at 4:15 a m.
The CAUSE OF DEATH* was as follows:
Premature birth
Mother with Lobar
Pneumonia
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Edwin Cutler M. D.
4-13, 1930 (Address) Shelly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls - Idaho
Date of Burial: Apr. 14 1930

20. Undertaker: none
Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20472

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 21 50
Local Registrar's No. 56
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

71 B

2. FULL NAME Darwin L. Messick
(a) Residence. No. Basalt, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec. 19, 1928
7. AGE Years 1 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Basalt, Idaho
PARENTS
10. NAME OF FATHER Joseph P. Messick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Josephine Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bear Lake Idaho
14. Informant Joseph P. Messick
(Address) Basalt, Idaho
15. Filed 4/3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 2 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-20, 1930, to 4-2, 1930
that I last saw him alive on 4-2, 1930
and that death occurred, on the date stated above, at 1:30 m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal, Meningitis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) None known
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) Edwin Cutler, M. D.
4-3, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Basalt
Date of Burial April 3 1930
20. Undertaker Jack A. Wood
Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 24 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20423

County of Bonneville. Registration District No. 3
City of Idaho Falls Primary Registration District No. 214-D
Local Registrar's No. 70

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry H. Trowbridge.

(a) Residence. No. 341 Basalt St. St.
(Usual place of abode)
Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Elizabeth Trowbridge

6. DATE OF BIRTH (month, day and year): March 3-1847.

7. AGE: Years: 83 | Months: 1 | Days: 12. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10. NAME OF FATHER: Trowbridge
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Eliza Ann Foot.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs Elizabeth Trowbridge.
(Address) 341 Basalt St.

15. Filed June 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from one visit April 3rd 1930, to , 19
that I last saw her alive on 3rd day of April, 1930
and that death occurred, on the date stated above, at 5.30 P.M.
The CAUSE OF DEATH* was as follows:

a Gastric Ulcer & Pericarditis
One year or more (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Thomas C. Wilson M. D.
~~Idaho Falls~~, 19 April 16/30 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	April 20 1930
20. Undertaker	Address
V. F. McHan	Idaho Falls Ida.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11424

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 7120
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 69

129

2. FULL NAME James Lord

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 23-1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	9	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebo Ill.

PARENTS

10. NAME OF FATHER Jehabod Lord
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant J. P. Lord
(Address) Idaho Falls Ida.

15. Filed Apr 16, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to Apr 12, 1930
that I last saw h[illegible] alive on Apr 12, 1930
and that death occurred, on the date stated above, at 2.30 A m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremic Sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Laboratory
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nebo Ill	April 1930

20. Undertaker W. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20476

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2 1 V 0
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 67

2. FULL NAME Rulon M. Jensen

(a) Residence. No. [illegible] St. Basalt, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ellen Jensen

6. DATE OF BIRTH (month, day and year): Jan 26

7. AGE: Years 33; Months; Days; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogdenville, Utah

PARENTS

10. NAME OF FATHER: Lewis B. Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Alpine Idaho
12. MAIDEN NAME OF MOTHER: Mary Sorenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs. Ellen Jensen
(Address) Basalt Idaho

15. Filed Apr 14, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-11-, 1930, to 4-13-, 1930
that I last saw her alive on 4-13-, 1930
and that death occurred, on the date stated above, at 12-20 a m.

The CAUSE OF DEATH* was as follows:
Cerebral Abscess & Brain Softening
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Otitis Purulent Subacute Infection
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Yes Laboratory
What test confirmed diagnosis?
(Signed) Edwin Cutler, M. D.
4-14-, 1930 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Basalt Idaho — Date of Burial: April 18 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20477

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 66

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Riley North

(a) Residence. No. Swan Valley Hiway St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 9 1866.

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	4	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mill Creek Utah.

PARENTS

10. NAME OF FATHER Lewi North.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER M K Rasmussen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Geraldine Layton
(Address) Gridley Calif.

15. Filed Jun 6, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13. 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Probably
Myocarditis
Chronic,
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High Blood Pressure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination and Statements

(Signed) C. H. Gale Coroner M. D.
Apr. 16 19 30 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker W. F. McHan	Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20478

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2, V-D
(No. I. F. L. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6 V-

2. FULL NAME Ira Cox

(a) Residence. No. 1010 St. Shelley Route #1
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph R. Cox

6. DATE OF BIRTH (month, day and year): July 4, 1895

7. AGE: Years 34 | Months 9 | Days 9 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bear Lake, Idaho

PARENTS

10. NAME OF FATHER: Joseph Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Anna M. Petersen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Joseph R. Cox
(Address): Shelley Rt. #1

15. Filed Apr. 17, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-9-, 1930, to 4-13-, 1930
that I last saw her alive on 4-13-, 1930
and that death occurred, on the date stated above, at 10-30 a. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary): Acute Nephritis

(duration) yrs. mos. 7 ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) Edwin Cutler, M. D.
4-14-, 1930 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Taylor, Idaho — Date of Burial: April 16 1930
20. Undertaker: Jack W. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6479

Local Registrar's No. 64

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No.
Primary Registration District No.
(No. I. F. L. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Cox

(a) Residence. No. 161a St. Shelley Rt #1
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12, 1930

7. AGE — Years: — Months: — Days: 1 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS

10. NAME OF FATHER: Joseph P. Cox
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Taylor Idaho
12. MAIDEN NAME OF MOTHER: Ira Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bear Lake, Idaho

14. Informant: Mrs Joseph P. Cox
(Address) Shelley Rt #1

15. Filed April 14, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month), 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-12-, 1930, to 4-13, 1930
that I last saw her alive on 4-13-, 1930
and that death occurred, on the date stated above, at 4-13 a m.

The CAUSE OF DEATH* was as follows:
Premature birth, 8 months child.
Mother Had Lobar Pneumonia
Acute nephritis.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Edwin Cutler, M. D.
4-14, 1930 (Address) Shelley Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Taylor, Idaho — Date of Burial: April 16 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70480

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

45

2. FULL NAME Harry W. Fletcher
(a) Residence. No. Grand Hotel St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE About Years 65 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not "
12. MAIDEN NAME OF MOTHER Not "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not "

14. Informant Ira Fisher
(Address) Idaho Falls, Idaho

15. Filed Apr 12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27, 1930, to April 10, 1930
that I last saw him alive on April 10, 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum & extended to Liver
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of April-3-30
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) H. D. Spencer, M. D.
Apr 12, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Van Wert, Iowa
Date of Burial April 15 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70481

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2 14-0
Local Registrar's No. 62

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Wyatt B. Jones
(a) Residence. No. Shelley Idaho R.S.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie L. Jones

6. DATE OF BIRTH (month, day and year) 4-3-1938

7. AGE Years 68 Months 6 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brownville Missouri

PARENTS
10. NAME OF FATHER J. K. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER — — Bayless.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Charlie E. Jones
(Address) Shelley R-2

15. Filed Apr 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) - 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-31, 1930, to 4-3-, 1930
that I last saw him alive on 4-3-, 1930
and that death occurred, on the date stated above, at 9:45 p.m.
The CAUSE OF DEATH* was as follows:
Acute dilation of the heart.
..... (duration) ..... yrs. ..... mos. 6 hrs.
CONTRIBUTORY (Secondary) Lobar Pneumonia.
..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Edwin Kuller M. D.
4-4-, 1930 (Address) Shelley Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot Cemetery
Date of Burial 4-6-1930

20. Undertaker Jack A. Wood.
Address Idaho Falls Ida.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers**, who receive a definite salary), may be entered as **Housewife, Housework, or At home**, and children, not gainfully employed, as **At school or At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated **unknown.**

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

N # 9

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20482

PLACE OF DEATH
County of Bonneville. Registration District No. 22
City of Idaho Falls Primary Registration District No. 21-0
Local Registrar's No. 61

(No. 74A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nels Rosengreen.
(a) Residence. No. 183 Longfellow Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 15. 1846
7. AGE: Years 83 | Months 9 | Days 20. | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Sweden.

PARENTS
10. NAME OF FATHER Jons Rosengren.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Anna Christina
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Joe Hall.
(Address) Idaho Falls. Ida
15. Filed May, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 5 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to April 4, 1930
that I last saw h[illegible] alive on April 3, 1930
and that death occurred, on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo. A. Kupferle M.D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan Utah. Date of Burial: April 7 1930
20. Undertaker: W. F. McHan Address: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70483

PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Idaho.

Registration District No. 73
Primary Registration District No. 2 [illegible] 0
(No. L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

131

2. FULL NAME Frank Gustav Lundquist.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or ~~XXXXXX~~): Matilda Lundquist.

6. DATE OF BIRTH (month, day and year): March 20, 1862

7. AGE: Years 68, Months 1, Days 0. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Carl Lundquist.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Christina Anderson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Frank Lundquist.
(Address) Rigby, R. #3

15. Filed May 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 20, 1930
that I last saw him alive on April 20, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Uremia

..... (duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Hemorrhagic Necrotic Kidney
Pyelo Nephrosis
..... (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death? Lorenzo, Idaho
Did an operation precede death? Yes Date of Apr 17-1930
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Annis
Date of Burial: 4/23/30 19

20. Undertaker: A B Eckersell
Address: Rigby

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10484

PLACE OF DEATH
County of Bonneville
City of Idaho Falls,

Registration District No. 73
Primary Registration District No. 2140
(No. Spencer Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

2. FULL NAME Shirley Smith.

(a) Residence. No. ____ St. Rigby, Idaho. 100A
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.M.	White	Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) July 24, 1926

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	3	8	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Lorin Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Jennie Lucile Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs. Lorin Smith
(Address) Rigby, Idaho.

15. Filed May 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1930, to Apr 14, 1930
that I last saw her alive on Apr 13, 1930
and that death occurred, on the date stated above, at 5.45 p.m.
The CAUSE OF DEATH* was as follows:

Pneumonia (bronchial)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ____

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.
4-30, 1930 (Address) Rigby

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho	4/16/30

20. Undertaker [signature] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10485

Registration District No. 3
Primary Registration District No. 24
Local Registrar's No. 83

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Lester Campbell

(a) Residence. No. Wordville, Idaho St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 19 1914

7. AGE: Years 16 | Months 3 | Days 5 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ammon, Idaho

PARENTS

10. NAME OF FATHER: O. C. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Minerva C. Peel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Mrs. O. C. Campbell
(Address) Wordville, Idaho

15. Filed Ap. 24, 1923 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-17-, 1930, to 4-24-, 1930
that I last saw him alive on 4-23-, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:
Streptococcic Infection of Blood.
(duration) ... yrs. ... mos. 10 ds.
CONTRIBUTORY (Secondary): Tonsilites
(duration) ... yrs. ... mos. 7 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no. Date of ...
Was there an autopsy? no.
What test confirmed diagnosis? Laboratory Ex. blood.
(Signed) Edwin Crellin, M. D.
4-25-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho	April 27 1930
20. Undertaker	Address
Jack A. Ward	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20486

Registration District No. 73
Primary Registration District No. 2 IV-6
Local Registrar's No. 52

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No.) Spencer Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Maynard Heston

(a) Residence. No. 386 - Lee Street St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 18, 1929

7. AGE: Years | Months: 4 | Days: 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: John Heston
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Evelyn Louise Hamm
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Alabama

14. Informant: John Heston
(Address) Idaho Falls, Idaho

15. Filed Apr. 24, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to Apr 26, 1930
that I last saw him alive on Apr 26, 1930
and that death occurred, on the date stated above, at 7-30 a.m.
The CAUSE OF DEATH* was as follows: Bronchitis & Toxic Intoxication
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. D. Spencer, M. D.
Apr 30, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS and NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	April 27 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED MAY 24 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20487

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 1 V-0

Local Registrar's No. 41

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Chas Warren

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 1859.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	0	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Farm.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Clark.

(Address) Ririe Ida

15. Filed May 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to Apr 23, 1930

that I last saw him alive on April 23, 1930

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) [signature], M. D.

May 1, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 4/27 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70488

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1471
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 40

131

2. FULL NAME Anna Maria Mallory
(a) Residence. No. Shelley, Idaho St. Shelley, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Warren James Mallory

6. DATE OF BIRTH (month, day and year) December 31, 1872

7. AGE Years 57 Months 3 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS
10. NAME OF FATHER E. N. Freeman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) United States
12. MAIDEN NAME OF MOTHER Anna M. Poulsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant W. F. Mallory
(Address) Shelley, Idaho.

15. Filed Apr. 28, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1930, to April 27, 1930
that I last saw her alive on April 27, 1930
and that death occurred, on the date stated above, at 9:15 A m.
The CAUSE OF DEATH* was as follows: Following Rt Nephrectomy for malignant tumor of kidney
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Diabetes mellitus
(duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of April 26, 1930
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) H Ray Hatch, M. D.
April 28, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salt Lake City, Utah — Date of Burial April 30 1930

20. Undertaker Jack A. Wood — Address Idaho Falls

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20497

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 3
Primary Registration District No. 21 V-0
Local Registrar's No. 77
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesse Boyd Whitehead

(a) Residence. No. [illegible] Iona, Idaho St. 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 21, 1929

7. AGE: Years | Months 8 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: Fulon S. Whitehead
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Shelley Idaho
12. MAIDEN NAME OF MOTHER: Ellen James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Fulon S. Whitehead
(Address) Iona, Idaho

15. Filed April 14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 17, 1930
that I last saw him alive on April 17, 1930
and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Streptococci Peritonitis
Ruptured appendix.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ileo Colitis
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Iona
Did an operation precede death? Yes Date of 4/17/30
Was there an autopsy?
What test confirmed diagnosis? Operation

(Signed) [signature], M. D.
4/18, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona Idaho — Date of Burial: April 20 1930

20. Undertaker: Jack O. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20492

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 21-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76
161a

2. FULL NAME Aiko Endo
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female ~~Male~~
4. COLOR OR RACE Yellow
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 15, 1930
7. AGE Years Months Days 3 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS
10. NAME OF FATHER Unokichi Endo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Jan Endo
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant Mr. Unokichi Endo
(Address) Idaho Falls, Idaho

15. Filed Jn 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 18, 1930
that I last saw her alive on April 15, 1930
and that death occurred, on the date stated above, at 10-A. m.
The CAUSE OF DEATH* was as follows:
Patent Foramen Ovale.
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Premature Baby 8 mo
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Stethoscope
(Signed) [signature] M. D.
4/18, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial April 18 1930
20. Undertaker Jack A Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20494

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No.
Primary Registration District No.
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

100a

2. FULL NAME Milan Wood
(a) Residence. No. Driggs, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of June 12, 1928

6. DATE OF BIRTH (month, day and year) June 12, 1928

7. AGE Years 1 Months 10 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho

PARENTS
10. NAME OF FATHER Elba Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Driggs, Idaho
12. MAIDEN NAME OF MOTHER Elsie Nichols
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant M. Elba Wood
(Address) Driggs, Idaho

15. Filed Apr 17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to April 14, 1930
that I last saw him alive on April 13, 19
and that death occurred, on the date stated above, at 5-20a m.
The CAUSE OF DEATH* was as follows:

~~Bronchi~~
Bronchial pneumonia
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumococcic Meningitis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Driggs.
Did an operation precede death? No Date of
Was there an autopsy? No Xray
What test confirmed diagnosis? Spinal pneumatic
(Signed) [signature], M. D.
4/14, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Driggs, Idaho Date of Burial April 16 1930

20. Undertaker Jack A. Wood Address Idaho Falls

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20495

PLACE OF DEATH
County of Bonneville
City of Idaho Falls Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 73
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kessler Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 4 1924

7. AGE: Years 6 | Months 0 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Victor Idaho

PARENTS

10. NAME OF FATHER: Christen Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Logan Utah
12. MAIDEN NAME OF MOTHER: Mary Folly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Neph Utah

14. Informant: Mrs Mary Peterson
(Address) Victor Idaho

15. Filed May 24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April-23-, 1930, to April-24-, 1930
that I last saw him alive on April-24-, 1930
and that death occurred, on the date stated above, at 5257 m.

The CAUSE OF DEATH* was as follows:

Non-infectious Coma - cause unknown

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? — Date of —
Was there an autopsy? None
What test confirmed diagnosis? Clinical findings

(Signed) Dr. Gill Crockett, M. D.
April-24, 1930 (Address) Interne of L.D.S. Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Victor Idaho	April 25 1930
20. Undertaker	Address
J. F. McHan	Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20496

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 73
Primary Registration District No. 21-6
Local Registrar's No. 73

(No. 109 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Coles.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Almeda Coles.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cedar Fort Utah.

PARENTS

10. NAME OF FATHER Reuben Coles.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Hannah
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Henry A. Coles.
(Address) Rigby, # 2. - Ida.

15. Filed April 24, 1930 C. Sumsion Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1930, to April 21, 1930
that I last saw him alive on April 19, 1930
and that death occurred, on the date stated above, at 3:15 P. m.
The CAUSE OF DEATH* was as follows:
Peri Pharyngeal cellulitis

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Toxic Goitre
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) W. Ray Hatch, M. D.
April 24, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby Idaho	April 24 1930

20. Undertaker Thos. J. Keller Address Rexburg

STUDY THE FOLLOWING INSTRUCTIONS CAREFULLY—THIS IS A PERMANENT RECORD
CAUSE OF DEATH. This information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS are very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20497

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 13

Primary Registration District No. 2150

Local Registrar's No. 71

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Gerald Clayton Gulixson

(a) Residence. No. 13 & June Sts. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. ✓ yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 7 - 1929.

7. AGE: Years 0 Months 6 Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER Chas Gulixson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bode. Iowa

12. MAIDEN NAME OF MOTHER Laura Fothergill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane Co Wash.

14. Informant Chas Gulixson
(Address) Idaho Falls. Ida.

15. Filed Apr. 19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 18 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 18, 1930 that I last saw him alive on April 18, 1930 and that death occurred, on the date stated above, at 5,45 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. A. Aupperle M. D.

Apr. 19, 1930 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 4/20 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20498

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

(No. Samaritan Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME Clark M. Keith

(a) Residence. No. (rural) St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

40

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	----------

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/4/30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
-----	---	3	

8. OCCUPATION OF DECEASED ---- -

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS

10. NAME OF FATHER S.A.Keith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Ethel Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant S.A.Keith

(Address) Durkee, Ore.

15. Filed 5-7, 1930 Lettie Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 4, 1930
that I last saw h-- alive on May 4, 1930
and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W.C. Wolfe M.D., M. D.

5/10/30 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cemetery	5/7/30 19
20. Undertaker Fred K. Robinson	Address Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 0006

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 6490

Local Registrar's No. 57

90

2. FULL NAME Jefferson D. Taggart.

(a) Residence. No. Rural St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Dec. 19, 1870

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	4	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10. NAME OF FATHER -----

11. BIRTHPLACE OF FATHER (city or town) (State or Country) -----

12. MAIDEN NAME OF MOTHER -----

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) -----

14. Informant Esler Taggart

(Address) Nampa Ida. (Rural)

15. Filed 5-8, 1930 Bertha Conway Registrar

V. C. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to May 7, 1930

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart,

..... (duration) few minutes hrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. C. Bell M. D.

May 8, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlelawn Cem	5-9 1930

20. Undertaker F.K. Robinson Address Nampa Id

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70501

Registration District No. 3
Primary Registration District No. 1006
Local Registrar's No. 59

PLACE OF DEATH
County of Canyon
City of Nampa
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William John Rankin

(a) Residence. No. 420 - 9th Ave. S. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Ida Rankin

6. DATE OF BIRTH (month, day and year): March 19-1853

7. AGE — Years: 77 | Months: 1 | Days: 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Wheeling Virginia

PARENTS
10. NAME OF FATHER: William Rankins
11. BIRTHPLACE OF FATHER (city or town) (State or Country):
12. MAIDEN NAME OF MOTHER: Lydia Watkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mt Pleasant Ohio

14. Informant: X Mrs. C. M. Baker
(Address) 420 - 9 Ave So Nampa Ida

15. Filed 5-12, 1930 Retta Conway Registrar
Rose

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to May 9, 1930
that I last saw him alive on May 9, 1930
and that death occurred, on the date stated above, at 1130 P m.
The CAUSE OF DEATH* was as follows:
Left sided Paralysis

(duration) yrs. 7 mos. ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical symptoms
(Signed) H. P. Rose, M. D.
May 10, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverslawn Cem — Date of Burial: 5-12 1930
20. Undertaker: Fred K Hinson — Address: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20592

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1606
Local Registrar's No. 60
(No. 215 - 10th Ave. No)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha Lewis
(a) Residence. No. Midway District St.
(Usual place of abode.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of S. E. Lewis

6. DATE OF BIRTH (month, day and year) April 17th 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	—	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER John Wherrett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Adeline Hunt
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Maine

14. Informant Mrs. V. A. Pierce
(Address) Nampa Idaho

15. Filed 5-12, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to May 9, 1930, that I last saw him alive on May 4, 1930, and that death occurred, on the date stated above, at 9:15 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Cancer of Breast
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V. C. Beemer M. D.
5-12, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 5-12 1930
20. Undertaker: Mrs. Nina M. Talley Address: Nampa Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20503

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 61

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Richard P. Snead.

(a) Residence. No. 19 -22ave.S St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct.16,1845

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Greef Snead
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Lucy Trout
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Hosea Snead
(Address) Nampa Ida.

15. Filed 5/12, 1930 Bertha Conway Registrar
Murray

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1925, to May 12, 1930
that I last saw him alive on May 12, 1930
and that death occurred, on the date stated above, at 9 30 a. m.
The CAUSE OF DEATH* was as follows:
Senile gangrene of lower limbs
(duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Senile arteries
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Closure of arteries
(Signed) J H Murray, M. D.
May 12, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn
Date of Burial: 5/13 1930

20. Undertaker: F.K. Robinson
Address: Nampa Ida.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20594

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 62
(No. 415-15th Ave So)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Hornbeck 49

(a) Residence. No. 415-15th Ave So St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Wm Peter Hornbeck

6. DATE OF BIRTH (month, day and year) April 21st

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Geo. W. Kennedy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Caroline Sandell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweden

14. Informant Mrs. Ezra Rydalch
(Address) Nampa, Idaho

15. Filed 5-16, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-8, 1929, to 5-13, 1930
that I last saw her alive on 5-13, 1930
and that death occurred, on the date stated above, at 6 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Medistinum, closing esopheagus causing inanition

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms
(Signed) H. C. Robinson, M. D.
5-14, 1930 (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn-Nampa	5-16 1930
20. Undertaker	Address
Mrs. Nina M. Talley	Nampa, Ida.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20505

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 64
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Farrell

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 12 - 71

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ia

PARENTS
10. NAME OF FATHER J. B. Findley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Winston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs Luke Mangum
(Address) Nampa Ida

15. Filed 5/17, 1930 Della Comingay Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1929, to May 15, 1930
that I last saw her alive on May 15, 1930
and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:
Cancer Lungs ?
Stomach

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer Breast
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? yes Date of Sept. 12. 29
Was there an autopsy? No
What test confirmed diagnosis? Laboratory

(Signed) W. C. Wolfe, M. D.
May 17, 1930 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	5-17 1930
20. Undertaker F. K. Robinson	Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20506

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 65
(No. 605-13th Ave. No)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Irene May Randall 6B
(a) Residence. No. 605-13th Ave. No St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) April 25th 1902
7. AGE Years 28 Months — Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Dry goods
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Sugar Grove Wisconsin

PARENTS
10. NAME OF FATHER Peris Randolph Randall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Viraqua Wisconsin
12. MAIDEN NAME OF MOTHER Alice Clare Moses
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Chippewa Falls Wisconsin

14. Informant (Address) Mrs. Alice Randall Nampa, Idaho
15. Filed 5/21, 1930 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to —, 19..
that I last saw her alive on May 18, 1930
and that death occurred, on the date stated above, at 11:30 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Addisons Disease
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Billings M. D.
May 21, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 5-22 1930
20. Undertaker Mrs. Nina M. Talley
Address Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20507

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
(No. 2½ miles south Nampa)
Local Registrar's No. 66
(If death occurred in a hospital or institution, give its name instead of street and number.)

143a

2. FULL NAME Ada F. Sword

(a) Residence. No. 2½ miles so. Nampa St.
(Usual place of abode.)
(If nonresident give city or town and State.)
Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Color	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J. J. Sword

6. DATE OF BIRTH (month, day and year) December 14th 1897

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER E. M. Wine
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Emma D. Faudie
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Mrs. M. M. Wine Nampa Idaho

15. Filed 5/22, 19.. Ben Fenton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-18, 1930, to 5-19, 1930
that I last saw her alive on 5-19, 1930
and that death occurred, on the date stated above, at 11:50 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septic Abortion.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of 5-18-30
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) J. Chorton, M. D.
5-21, 1930 (Address) Lawyer Idaho.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 5-23 1930
20. Undertaker: Mrs. Nina M. Talley, Nampa Idaho — Address

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70508

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 67
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hazel Irene Barnard

(a) Residence. No. 423-20th-Ave. S. St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Married

5a. If married, widowed, or divorced (HUSBAND of) (or) WIFE of Ivan P.Barnard

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) House Wife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida.

PARENTS
10. NAME OF FATHER Howard Bair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kanses
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknwn

14. Informant Ivan P. Barnard.
(Address) Nampa Ida.

15. Filed 5/22, 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 22 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 22, 1930, that I last saw her alive on May 22, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilitation
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Bronchial Pneumonia
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel A Swayne, M. D.
May 22, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Ida.	19

20. Undertaker	Address
F.K. Robinson	Nampa Ida.

H.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 9503

Local Registrar's No. 68

44

2. FULL NAME L J Creason

(a) Residence. No. ..... Rural ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-27-58

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER W. B. Creason

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Feuney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs L. J. Creason

(Address) Nampa Ida

15. Filed 5/24, 1930 Estella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to May 19, 1930

that I last saw ~~him~~ alive on May 19, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer Stomach

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) W. C. Wolfe, M. D.

May 24, 1930 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Farmers Cem	5-25-1930

20. Undertaker	Address
F K Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70511

Registration District No. 3
Primary Registration District No. 2057
Local Registrar's No. 24

PLACE OF DEATH

County of Canyon
City of Parma

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

15-4c

2. FULL NAME Perhall

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE — Years — Months — Days — If LESS than 1 day, One hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Parma Idaho RR #2

PARENTS

10. NAME OF FATHER C B Perhall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash.
12. MAIDEN NAME OF MOTHER Edna May Weir
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kan.

14. Informant W. M. Mitchell
(Address) Parma Idaho

15. Filed 5/14, 1930 Lulu Waldron Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1930, to May 14, 1930
that I last saw h[illegible] alive on Stillborn, 19....
and that death occurred, on the date stated above, at E. D. m.
The CAUSE OF DEATH* was as follows:
Stillborn,
Absence of anal Orefice
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Stillborn
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W M. Mitchell, M. D.
5/14, 1930 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70512

PLACE OF DEATH
County of Malheur
City of Parma
P.O.

Registration District No. 3
Primary Registration District No. 2007 . Local Registrar's No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline Lewison
(a) Residence. No. Parma #3 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 5-1856

7. AGE Years 73 Months 7 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloit Wisconsin

PARENTS
10. NAME OF FATHER Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Norway

14. Informant (Address) Leo H. Lewison Parma #3

15. Filed 6/7, 1930 Luler Waldorf Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to June 5, 1930
that I last saw her alive on June 3, 1930
and that death occurred, on the date stated above, at 8 PM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary
Tuberculosis

..... (duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Sputum poo.
(Signed) M Montgomery M. D.
6/4, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Roswell
Date of Burial 6-6 1930

20. Undertaker C. V. Peckham
Address Caldwell Ida

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70514

PLACE OF DEATH
County of Canyon
City of Caldwell — Registration District No. 3
Primary Registration District No. 1005 — Local Registrar's No. 5

(No.) (If death occurred in hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel E. Goodloe

(a) Residence. No. 1009 Blvd St. (Usual place of abode.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Goodloe

6. DATE OF BIRTH (month, day, and year) Oct 7 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	7	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Andrew Co. Missouri

PARENTS

10. NAME OF FATHER John R. Goodloe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Andrew Co Missouri
12. MAIDEN NAME OF MOTHER Sarah A. Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant Mary E. Goodloe (Address) Caldwell Ida.

15. Filed 5-15- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to May 18. 1930 that I last saw him alive on May 18 1930 and that death occurred, on the date stated above, at 12-30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) moderate yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) David E. Bassett, M. D.
May 14, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	5/15 1930
20. Undertaker	Address
E. V. Peckham	Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JUN 11 1930

DO NOT WRITE IN THIS SPACE
State File No. 70515

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 9
Primary Registration District No. 2005
Local Registrar's No. 55
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William B. Stanley
(a) Residence. No. Route 1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Betty M. Stanley

6. DATE OF BIRTH (month, day and year) Aug 1st 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	9	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS
10. NAME OF FATHER John T. Stanley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Mary Robins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) North Carolina

14. Informant (Address) Mrs Bettie M Stanley Route 1 Ida

15. Filed 5-17-, 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to May 16, 1930
that I last saw h[illegible] alive on May 14, 1930
and that death occurred, on the date stated above, at 10-20 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Multiple sclerosis
(duration) several yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Symptoms
(Signed) J. W. Caldwell, M. D.
5/16, 1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 5/18 1930
20. Undertaker: C. V. Richardson — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70516

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005 . Local Registrar's No. 56
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118a

2. FULL NAME Mrs Bessie Conroy
(a) Residence. No. Riverside, Caldwell Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Frank M.Conroy

6. DATE OF BIRTH (month, day and year) 3-24-1889

7. AGE Years 41 Months 1 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER John Sevy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Frank M.Conroy R F D Caldwell Idaho

15. Filed 5-23-, 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21-30, 19.. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 21, 1930
that I last saw her alive on May 21, 1930
and that death occurred, on the date stated above, at 1 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Strangulated Umbilical Hernia - Operation - Shock & Heart
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Umbilical Hernia of years standing
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 20/30
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) T. D. Farrer M. D.
5/23, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery
Date of Burial: May 23-30

20. Undertaker: Paul L.Case
Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70517

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 58
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Benjamine F. Hartkopf
(a) Residence. No. 12 13 albany St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs Margaret Hartkopf

6. DATE OF BIRTH (month, day and year) Dec 10 1849

7. AGE Years 80 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lock smith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Ohio

PARENTS
10. NAME OF FATHER Daniel Hartkopf
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Ralph Beal 7" St. Caldwell Idaho

15. Filed 5-25-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1930, to May 22, 1930
that I last saw him alive on May 21, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Uremia at intervals since March 1930 (duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J M Kaley, M. D.
2-23-, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: May 25 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 3

DO NOT WRITE IN THIS SPACE
State File No. 70518

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 59
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Edward Mahan Eustace

(a) Residence. No. 1413 Dearborn St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1 1917

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	--	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER M.H.Eustace

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vernon Co. Mo.

12. MAIDEN NAME OF MOTHER Jane Mahan

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Charleston W.Va.

14. Informant M.H.Eustace
(Address) Caldwell Idaho

15. Filed 9-29-, 1930. John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27-30, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Drowning. Accidental

No Inquest.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Paul L. Case M. D.
May 28 1930, 19..... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: May 29-30

20. Undertaker: Paul L.Case — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70519

PLACE OF DEATH
County of Malheur
City of Vale

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 60
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME James J. Rutherford
(a) Residence. No. Homedale, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug

7. AGE: Years 68 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Landholm Scotland

PARENTS
10. NAME OF FATHER: Rutherford
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Margaret Johnstone
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Scotland

14. Informant (Address): Bertha V. Campbell Baker Ore Bx 579

15. Filed 6-4- 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to May 28, 1930
that I last saw him alive on May 28, 1930
and that death occurred, on the date stated above, at 5 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

Nephritis (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V. D. Tower, M. D.
5/31, 1930 (Address) Caldwell Id.

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: June 1" 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Id.

K.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70520

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 . Local Registrar's No. 61
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME James M. Cook
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah E. Cook

6. DATE OF BIRTH (month, day and year): Oct 19-1846

7. AGE: Years 83, Months 7, Days 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer - Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Marion County Ohio.

PARENTS

10. NAME OF FATHER: James L. Cook.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scioto Co. Ohio.
12. MAIDEN NAME OF MOTHER: Lucinda Little John.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Scioto Co. Ohio.

14. Informant (Address): Jessie M. Cook 223 Aven.

15. Filed 6-4-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to May 29, 1930
that I last saw him alive on May 29, 1930
and that death occurred, on the date stated above, at 2 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) 2 mos. ds.
CONTRIBUTORY (Secondary): Prostatitis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) M. Kaley, M. D.
6-3-30 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: May 31 1930

20. Undertaker: C. V. Peckham. Address: Caldwell Ida

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20521

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 62-
(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christina Wall Anderson
(a) Residence. No. Caldwell, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Erick Anderson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sunne, Sweden

PARENTS
10. NAME OF FATHER Nils Wall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sunne Sweden
12. MAIDEN NAME OF MOTHER Kate Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sunne Sweden

14. Informant (Address) Erick Anderson Caldwell - Idaho -

15. Filed 6-1-, 1930. John S. Meyer - Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to May 29, 1930
that I last saw her alive on May 28, 1930
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
5/31, 1930 (Signed) [illegible] M. D.
(Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: June / 1930
20. Undertaker: Paul L. Case — Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6522

JUN 11 1930

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 63
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence Lee Morris 41
(a) Residence. No. Notus, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11 - 1915

7. AGE Years 14 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Troy Kansas

PARENTS
10. NAME OF FATHER H. B. Morris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denton Kansas
12. MAIDEN NAME OF MOTHER Alma Porter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Hemingford Neb.

14. Informant (Address) H. B. Morris

15. Filed 6-5, 1930 John F. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 1930, to May 31, 1930
that I last saw his alive on May 31, 1930
and that death occurred, on the date stated above, at 9 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Septicemia following Sinus Thrombosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Mastoiditis
(duration) yrs. 1 mos. 14 ds.

18. Where was disease contracted if not at place of death? Notus Idaho
Did an operation precede death? yes Date of Apr 10
Was there an autopsy? No
What test confirmed diagnosis? Blood & Cerebral Spinal fluid
(Signed) A. C. [illegible] M. D.
6/3, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 6-3 1930

20. Undertaker Paul L. Case
Address Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6523

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 64
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME C. William Johnston 101a
(a) Residence. No. 222 Aven St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 63. Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER James Johnston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Rhode Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant (Address) Mrs L. Johnston Caldwell Ida.

15. Filed 6-2-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, that I attended deceased from May 23rd 1930 to May 31, 1930
that I last saw him alive on May 31, 1930
and that death occurred, on the date stated above, at 8 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia - Tobar

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Flu - Exposure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) P. D. Forrer M. D.
6/2, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 6-2-1930

20. Undertaker Paul L. Case
Address Caldwell

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 4523

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 66
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

147

2. **FULL NAME** George Ray

(a) Residence. No. 1015 Albany St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Mrs. Leora M Ray

6. DATE OF BIRTH (month, day and year) Oct 22, 1880

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49.	7	10.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grove City Penn.

PARENTS

10. NAME OF FATHER Hugh Ray
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Butler Co. Harmsville Penn.
12. MAIDEN NAME OF MOTHER Mariah Albri
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mercer Co. Pine Grove, Penn.

14. Informant (Address) V. A. Cox 210 N. 10th Boise

15. Filed 6-4-, 1930. John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Head and chest crushed by electric elevator. Accidental.
Inquest verdict "Accidental death.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Cox, M. D.
Coroner.
June 4-30 19..... (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: June 5 1930

20. Undertaker: Paul L. Cox — Address: Caldwell Ida.
C. V. Peckham, Funeral Director

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70525

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 67

(No.) 740
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura Jane Hyde

(a) Residence. No. Caldwell #3 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb - 7 - 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Springfield
(State or country) Indiana

PARENTS

10. NAME OF FATHER Joseph L. Barkley
11. BIRTHPLACE OF FATHER (city or town) Dont know
(State or Country)
12. MAIDEN NAME OF MOTHER Josephine D. Medsker
13. BIRTHPLACE OF MOTHER (city or town) Dont know
(State or County)

14. Informant
(Address) Caldwell #3

15. Filed 6-9-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from May 7 -, 1930, to June 8, 1930
that I last saw her alive on , 1930
and that death occurred, on the date stated above, at 8 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) W. C. Wolfe M. D.
June 9, 1930 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal New Berg Date of Burial 19
20. Undertaker C. V. Anderson Address Caldwell Ida

Exact statement of OCCUPATION is very important.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10526

Registration District No. 87
Primary Registration District No. 2159
(No. Caribou Hospital)
Local Registrar's No. 19

PLACE OF DEATH

County of Caribou
City of Soda Springs

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose Norris

(a) Residence. No. Butte Montana St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State) Butte, Mont

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 47			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Managing Rooming House
(b) General nature of industry, business, or establishment in which employed (or employer): in Butte Mont
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Supposed to be Minn

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Florence Griffith
(Address) Soda Springs Idaho.

15. Filed 6/3, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 30, 1930
that I last saw her alive on May 30, 1930
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:
Tiamina J Left Shoulder,
Necrosis of Humerus
(Necrosis of upper Hum.)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Butte, Montana
Did an operation precede death? yes Date of 5/17/30
Was there an autopsy? 0
What test confirmed diagnosis? X-Ray
(Signed) Ellis Rackley, M. D.
6/3, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Luverne, Minn	June 6 1930
20. Undertaker: Ed D. Whitman	Address: Soda Springs Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 2 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

70526

Dr. Ellis Kackley
Soda Springs, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Rose Norris who died at Soda Springs, Idaho on May 30, 1930.
Cause of death given as "Trauma of left shoulder"

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Trauma resulted in Necrosis of upper Hum., infction developed.

Caribou JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20527

PLACE OF DEATH
County of ~~Bonneville~~ Bingham
City of Soda Springs Idaho
Registration District No. 8-2
Primary Registration District No. 2159
Local Registrar's No. 20
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha May Leavitt

(a) Residence. No. ..... Caribou, Wyo St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fe	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Delbert Leavitt

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
34	8	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer) V
(c) Name of employer V

9. BIRTHPLACE (city or town) (State or country) Wyo

PARENTS

10. NAME OF FATHER D. T. Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER May Walton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Edwin Smith
(Address) Soda Springs Idaho

15. Filed May 25, 1930 Dr. Russell Tippets Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 24, 1930
that I last saw he alive on May 23, 1930
and that death occurred, on the date stated above, at 12 midnight
The CAUSE OF DEATH was as follows: Frontal Sinus Infection

.....(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) V U
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? Yes Date of May 10, 1930
Was there an autopsy? U
What test confirmed diagnosis? Examination
(Signed) Russell Tippets, M. D.
5/24/, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, Cremation, or Removal	Date of Burial
Caribou, Wyo	5/27/30
20. Undertaker	Address
Miller & Wheelwright	Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70528

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

74a

2. FULL NAME John Schmidt

(a) Residence, No. ..... St. Albion Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Emma Schmidt

6. DATE OF BIRTH (month, day and year) Mar. 7, 1859

7. AGE: Years 71, Months 2, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Harry Schmidt
(Address) Burley Ida

15. Filed 5/16, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5/16/30 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/9/30, 19..., to 5/16/30, 19...
that I last saw him alive on 5/16/30, 19...
and that death occurred, on the date stated above, at 12:45 P m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertrophy Prostate

..... (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of 5/11/30
Was there an autopsy? 0
What test confirmed diagnosis? Cystoscopic
(Signed) Ellis Kaufly, M. D.
5/16/30, 19... (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal: Albion, Idaho — Date of Burial: May 20 1930

20. Undertaker: D. E. Johnson — Address: Burley

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20529

PLACE OF DEATH
County of Caribou
City of near Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name ~~instead of~~ street and number.)

Local Registrar's No. 17

45

2. FULL NAME John P. Haggerty
(a) Residence, No. Soda Springs St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Haggerty

6. DATE OF BIRTH (month, day and year) 1869-2-19

7. AGE Years 61 Months 2 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Paul Minn

PARENTS
10. NAME OF FATHER Patrick Haggerty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NA[illegible]ER Mo[illegible] McAndrew
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Harold Haggerty
(Address) Soda Springs Idaho

15. Filed 5-5-, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1929, to May 5, 1930
that I last saw him alive on May 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

about 1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? same
Did an operation precede death? no Date of 0
Was there an autopsy? no
What test confirmed diagnosis? Phys. Ex & X-Ray
(Signed) Russell Tigert, M. D.
5-5, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal Pocatello Idaho — Date of Burial 5-6 1930

20. Undertaker D. Whitman — Address Soda Springs Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70530

PLACE OF DEATH
County of Caribou
City of Soda Springs Idaho

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

188 C

2. FULL NAME Edmund Trindel
(a) Residence. No. Glenns Ferry Idaho St. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha I Trindel

6. DATE OF BIRTH (month, day and year) Aug 19 - 1874

7. AGE Years 55 Months 8 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Napoleon Indiana
(State or country)

PARENTS

10. NAME OF FATHER Alec Trindel
11. BIRTHPLACE OF FATHER (city or town) Napoleon Indiana
(State or Country)
12. MAIDEN NAME OF MOTHER Eliza Colvin
13. BIRTHPLACE OF MOTHER (city or town) Galesburg Illinois
(State or Country)

14. Informant Martin R. Trindel
(Address) Cozad Neb.

15. Filed 5-13-, 1930 Dr Russell Figart Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to after Death that I last saw him alive on after Death and that death occurred, on the date stated above, at about 10:30 a. m.

The CAUSE OF DEATH* was as follows:
Accidental (auto-wreck)
Fracture of vertebral
Column (cervical)
Instant
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Int. chest & abdom.
injuries (duration) Inst yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of 0
Was there an autopsy? No
What test confirmed diagnosis? Phys.
(Signed) Russell Figart, M. D.
May 13, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal Farnam Neb. | Date of Burial May 17 1930

20. Undertaker E. L. Whiteman | Address Soda Springs Ida

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis Marion Cutler

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nellie Grace Cutler

6. DATE OF BIRTH (month, day and year) July 4 1905

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	9	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) North Ogden
(State or country) Ut.

PARENTS

10. NAME OF FATHER Adelbert Cutler
11. BIRTHPLACE OF FATHER (city or town) Ogden
(State or Country) Utah New York
12. MAIDEN NAME OF MOTHER Sarah Ann Tracy
13. BIRTHPLACE OF MOTHER (city or town) Ogden
(State or County) Utah

14. Informant Mrs Francis M Cutler
(Address) Burley Idaho

15. Filed ..... 19 30 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 23 1930 to April 28 1930
that I last saw him alive on April 27 1930
and that death occurred, on the date stated above, at 4:15 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (duration) ..... yrs. ..... mos. 16 ds.
CONTRIBUTORY (Secondary) Congestion of Lower Lobes
Lung-Left (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symm
(Signed) Leland Jensen, M. D.
....., 19..... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal: Burley Ida. — Date of Burial: April 30 1930
20. Undertaker: W. C. Johnson — Address: Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

REC APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 0532

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred K Chapman 16

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 20, 1930

7. AGE Years | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida.

PARENTS

10. NAME OF FATHER Alfred Chapman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mary G Dayley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oakley

14. Informant (Address) A. Chapman Burley Ida.

15. Filed 5-12-, 1930 T. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 21, 1930
that I last saw him alive on April 21, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intra Uterine Asphyxia

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
April 22, 19..... (Address) Burley

19. Place of Burial, Cremation, or Removal: Burley Ida. | Date of Burial: April 22 1930

20. Undertaker: D. E. Johnson | Address: Burley

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Louise Frias

(a) Residence. No. ..... St. 101a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4, 1928

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana.

PARENTS

10. NAME OF FATHER Max Frias
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Adela Sandoval
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mexico

14. Informant (Address) Max Frias Burley Ida

15. Filed 5-12-, 1930 F. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 27, 1930
that I last saw her alive on Apr 26, 1930
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar bilateral

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) [illegible], M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial April 28 1930

20. Undertaker D. E. Johnson Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED APR 19 1930

DO NOT WRITE IN THIS SPACE

State File No. 70534

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Francis Marion Koontz

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eliza Koontz

6. DATE OF BIRTH (month, day and year) Aug 20, 1842

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER John Koontz

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mary Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant Ethel Smith
(Address) Burley Idaho

15. Filed 4-12-, 1930 E. E. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
April 10, 1930, to April 15, 1930
that I last saw him alive on April 10, 1930
and that death occurred, on the date stated above, at 2:45 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:-

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Hugh E. Mean, M. D.
April 16, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	April 18 1930
20. Undertaker	Address
D. C. Johnson	Burley

N. B.—Every item or information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 19 1930

TRANSPORTATION OF CORPSE

(Always write with black ink)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 0535

PLACE OF DEATH

County of Cassia Registration District No. .....

City of Burley Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Eldon J Banner

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1, 1930

7. AGE Years Months Days If ~~LESS~~ 5 than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida.

PARENTS

10. NAME OF FATHER Leo E Banner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Bertha C Silcock

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) Leo E Banner Burley Ida

15. Filed May 1 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1-30, 19....., to 4-1-, 1930

that I last saw him alive on 4-11, 1930

and that death occurred, on the date stated above, at 10 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Birth. Failure of closure of foramen ovales of heart

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Leland Frazier, M. D.

....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal Burley Ida. Date of Burial April 1 1930

20. Undertaker D. E. Johnson Address Burley

Information on this certificate is an exact COPY of the official certificate at place of death.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70536

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 96

Primary Registration District No. 2187

Local Registrar's No. 111

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Daphne McGinnis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Truman McGinnis

6. DATE OF BIRTH (month, day and year) Nov 11 1897

7. AGE Years 32 Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kendrick Idaho

PARENTS

10. NAME OF FATHER Arthur Skelton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jacksonville Alla.

12. MAIDEN NAME OF MOTHER Edna Carter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant Truman McGinnis
(Address) Pierce Ida

15. Filed 5/31, 19.... W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 28, 1930

that I last saw her alive on May 28, 1930

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows: "Heart" "Valvular"

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Menorrhagia

same (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? her home - Cardiff

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. M. Robertson M. D.

5/30, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Ida

Date of Burial 6/4 19

20. Undertaker W. D. Pinson

Address Orofino

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10537

PLACE OF DEATH
County of Shoshone
City of Orofino

Registration District No.
Primary Registration District No.
(No. Northern Idaho Sanitarium)
Local Registrar's No. 34
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Vallas

(a) Residence. No. St. Wallace, Idaho -
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 10 ds. How long in U. S., if of foreign birth? 7 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1898

7. AGE	Years	Months	Days	If LESS than 1 day,
	32	?	?	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Boorblack -
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10. NAME OF FATHER Unascertained.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 6/17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to May 15, 1930
that I last saw him alive on May 14, 1930
and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Syphilis -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Psychosis with Cerebro - Spinal Syphilis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory -

(Signed) John Irvine McKelvey M. D.
May 15 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Northern Idaho Sanitarium Cemetery — Date of Burial: May 16 1930
20. Undertaker: F. A. Billberg - Hosp. Attdt. — Address: Orofino. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10538

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 3107
Local Registrar's No. 30
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

20-A

2. FULL NAME Mary Ellen Strait

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J. P. Strait

6. DATE OF BIRTH (month, day and year) Mar 25 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work H.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER A. W. Barrow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J. B. Strait
(Address) Orofino

15. Filed 6/15, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-14, 1930, to 5-14, 1930
that I last saw her alive on 5-14, 1930
and that death occurred, on the date stated above, at 8 00 m.
The CAUSE OF DEATH* was as follows:
Accidental.
Died about 3 hrs

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Age (alcd)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. F. Robinson, M. D.
5/14, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wells Bench	May 15 1930
20. Undertaker W. D. Pinson	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70539

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 2[illegible]
Local Registrar's No. 38

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

174

2. FULL NAME John McNary

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 60 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): ✓

PARENTS
10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: W. A. Shaw Coroner
(Address) Orofino

15. Filed 5/15, 19.. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 19.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at 11,30 a m.
The CAUSE OF DEATH* was as follows:
Suicidal with Dynamite blowing the Head off
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. A. Shaw Coroner, M. D.
5/14, 19.. (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino | Date of Burial: 5/15 19

20. Undertaker: W. A. Shaw | Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20540

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Geo. Lowe

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 32 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clearwater Timber Co

9. BIRTHPLACE (city or town) (State or country): —

PARENTS

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (city or town) (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: W. A. Shaw Coroner

(Address) Orofino

15. Filed 5/ , 19 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/12, 1930, to 5/12, 1930

that I last saw him alive on 5/12, 1930

and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Laceration of lungs & abdominal organs

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Crushed by a falling tree (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. J. Hopkins M. D.

5/13, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida | Date of Burial: 5/14 19

20. Undertaker: W. A. Shaw | Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. D 0541

PLACE OF DEATH
County of Kootenai
City of Orofino

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Carlson

(a) Residence. No. 70 St. Laclede, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Gus Carlson

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day,
	29	?	?	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Long Prairie - Minnesota.

PARENTS

10. NAME OF FATHER William Ellersick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Lizzie Lemke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 6/10, 1930. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to May 8, 1930
that I last saw her alive on May 8, 1930
and that death occurred, on the date stated above, at 4 05 P. m.

The CAUSE OF DEATH* was as follows:
Sequellae of encephalitis lethargica

(duration) 3 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with other brain and Nervous diseases (duration) 3 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Howe McKelvey, M. D.
May 8, 1930 (Address) Orofino - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lapwai	
20. Undertaker	Address
[illegible]	[illegible]

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20542

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 21
Primary Registration District No. 2117
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

31

2. FULL NAME William H. Turner

(a) Residence. No. ..... St. Wallace, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 1885

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Waterloo - Iowa.

PARENTS

10. NAME OF FATHER William Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Catherine Carroll
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 6/5, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to May 5, 1930
that I last saw him alive on May 4 1930
and that death occurred, on the date stated above, at 6.05 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Alcoholic psychosis - Alcoholic deterioration (duration) 5 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis Physical Signs
(Signed) John Irvine McKelway, M. D.
May 5, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pendleton Orig
Date of Burial: 19

20. Undertaker: [signature]
Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70543

PLACE OF DEATH
County of [illegible]
City of Orofino

Registration District No. 90
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

101 B

2. FULL NAME Henry Stebbins

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 58 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ✓

PARENTS
10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: W. A. Shaw Coroner
(Address) Orofino

15. Filed 5/2, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30, 1930, to May 2, 1930
that I last saw him alive on May 2, 1930
and that death occurred, on the date stated above, at 12:30 A m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) — yrs. — mos. 3 ds.
CONTRIBUTORY (Secondary) Cardiac Failure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A. B. Pappenhagen, M. D.
May 3, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida | Date of Burial: 5/3 19

20. Undertaker: W. A. Shaw | Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20544

PLACE OF DEATH
County of Custer
City of Obsidian

Registration District No. 108
Primary Registration District No. 2186
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 108

2. FULL NAME Frank Wm Shaw

(a) Residence. No. Obsidian St.
(Usual place of abode)
Length of residence in city or town where death occurred. 37 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

74R

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Katherine B. Shaw

6. DATE OF BIRTH (month, day and year) Feb 12 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	71		20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher and
(b) General nature of industry, business, or establishment in which employed (or employer) cattle man
(c) Name of employer

9. BIRTHPLACE (city or town) Eau Claire Wis.
(State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant F. Preston Shaw
(Address) Obsidian Ida

15. Filed May 7, 1930 Elmer McKenney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to March 4, 1930
that I last saw h. im alive on March 4, 1930
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) E. W. [illegible], M. D.
3/4, 1930 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shaws Ranch	March 6 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAY 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10545

PLACE OF DEATH
County of Custer
City of Mackay Challis
Registration District No.
Primary Registration District No.
Local Registrar's No. 101

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hughie O'Rourke

(a) Residence. No. Mackay, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	wt	unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of V

6. DATE OF BIRTH (month, day and year) unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work mining
(b) General nature of industry, business, or establishment in which employed (or employer) x unemployed
(c) Name of employer V

9. BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant H. Brockman
(Address) Mackay, Idaho

15. Filed April 30, 1930 Edna M. McKinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to April 20, 1930
that I last saw h[illegible] alive on 4/20, 1930
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:

Cardiac asthma

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Tuberculosis of Lungs
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. L. Worley, M. D.
4/25, 1930 (Address) Challis, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mackay Idaho	April 26 1930
20. Undertaker	Address
Fred R. Garnier	Mackay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70546

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186 . Local Registrar's No. 100
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

163

2. FULL NAME Darrell Greenleaf Walker
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 1, 1930

7. AGE Years | Months 3 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Challis, Idaho

PARENTS

10. NAME OF FATHER Frank Elwood Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oxford Idaho
12. MAIDEN NAME OF MOTHER Gertrude Biswell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Centrullia Ill

14. Informant (Address) Sarah Elizabeth Walker Challis Ida

15. Filed April 3, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not attended by physician, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Probably improper food and exposure
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? .....
(Signed) C. L. Kirby, M. D.
4/3, 1930 (Address) Challis Idaho

19. Place of Burial, Cremation, or Removal: Challis, Idaho
Date of Burial: April 5 1930

20. Undertaker
Address

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 6541

PLACE OF DEATH

County of Custer
City of near Challis, Ida.

CERTIFICATE OF DEATH

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 104
(No.) 205-B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Bell Cook
(a) Residence. No. Challis, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE wt.
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) June 14 - 29

7. AGE Years Months 11 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Challis, Ida.

PARENTS
10. NAME OF FATHER R. C. Cook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Redmond, Utah
12. MAIDEN NAME OF MOTHER Star Macy Kellogg
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Las Animas, Colorado

14. Informant (Address) x R. C. Cook Challis, Ida Box 181

15. Filed May 27, 1930. Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
was called to see this child. Death occured before I saw it. Cause of death unknown.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Healthy child
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. L. Kirtley, M. D.
5/27, 1930 (Address) Challis, Ida.

19. Place of Burial, Cremation, or Removal Challis Ida. Date of Burial May 27 1930
20. Undertaker Theo R. Garmin Address Mackay, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 0543

PLACE OF DEATH
County of ~~Challis~~ Custer Co.
City of Challis

CERTIFICATE OF DEATH
Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 102
(No.) 48B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alex Calvin Watson
(a) Residence. No. Curvill, Texas St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Reeves Watson

6. DATE OF BIRTH (month, day and year) Jan. 31, 1862

7. AGE Years 68 Months 3 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10. NAME OF FATHER James Watson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Mary (unknown)
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Texas.

14. Informant (Address) Martha Challis, Idaho

15. Filed May 3, 1930 Edna McKinney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to May 2, 1930
that I last saw him alive on May 2, 1930
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. B. Kirtley, M. D.
5/4 1930 (Address) Challis, Ida

19. Place of Burial, Cremation, or Removal Challis, Idaho Date of Burial May 2 1930

20. Undertaker Theo. R. Garmin Address Mackay Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70549

PLACE OF DEATH

County of Elmore
City of Mt Home

CERTIFICATE OF DEATH

Registration District No. 34
Primary Registration District No. 2020
Local Registrar's No. 7
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia Ann Himebaugh 140
(a) Residence. No. Mountain Home 2 Ave St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elliot Himebaugh
6. DATE OF BIRTH (month, day and year) April 15
7. AGE Years 69 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Illinois
PARENTS
10. NAME OF FATHER Van Camp ~~Unknown~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓
14. Informant (Address) Elliot Himebaugh
15. Filed May 26, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to April 30, 1930
that I last saw her alive on April 30, 1930
and that death occurred, on the date stated above, at 1:30 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage in right fissure of Rolando - Paralized left side body, right side head (duration) - yrs. - mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic Brights disease (duration) 2 yrs. - mos. - ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O. P. Hamilton, M. D.
5-1-, 1930 (Address) Mtn. Home Idaho
19. Place of Burial, ~~Cremation, or Removal~~ Mountain Home
Date of Burial 5/3 1930
20. Undertaker G. C. Zacher
Address Mt Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 11556

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 34
Primary Registration District No. 2020
Local Registrar's No. 6
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William J. Newman

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Hotel clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10. NAME OF FATHER: William J. Newman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or County): ✓

14. Informant (Address): G. C. Zacher

15. Filed Apr 18, 1930 — Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-4-, 1929, to 4-17-, 1930, that I last saw him alive on 4-15-, 1930, and that death occurred, on the date stated above, at 1.04 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Microscopic

(Signed) G. C. Zacher, M. D.
4-18, 1930 (Address) Mt. Home

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Patterson Ohio	
20. Undertaker: G. C. Zacher	Address: Mt Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20551

PLACE OF DEATH

County of Franklin

City of Minkcreep

Registration District No.

Primary Registration District No.

Local Registrar's No. 48

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME James C. Rasmussen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Engra Rasmussen

6. DATE OF BIRTH (month, day and year): Nov 2 1845

7. AGE: Years 84 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED: none

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): denmark

PARENTS

10. NAME OF FATHER: Christensen Rasmussen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Christena Hootsfeldt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: James E Rasmussen
(Address) Weston Idaho

15. Filed , 19 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

natural death
cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) M Hancey, M. D.
Coroner

, 19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Minkcreek Idaho Date of Burial: May 26 1930

20. Undertaker: M. W. Hendricks Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10552

PLACE OF DEATH

County of Franklin

City of Weston

Registration District No.

Primary Registration District No.

Local Registrar's No. 47

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dwaine Fife

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
m le	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 7 1922

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	4	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weston Idaho

PARENTS

10. NAME OF FATHER Luther Fife

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Providence Utah

12. MAIDEN NAME OF MOTHER Inez Hemingway

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Luther Fife
Informant
(Address) Weston Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/18, 1930, to 5/18, 1930, that I last saw him alive on 5/18 19, 1930, and that death occurred, on the date stated above, at 5/30 a.m. The CAUSE OF DEATH* was as follows:

Pneumonia Catarrhal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Ward

(Signed) John B Holder, M. D.

, 19 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Weston Idaho	May 22 30
20. Undertaker	Address
M. W. Hendricks	Preston

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10553

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

1930

2. FULL NAME Ruth McBride

(a) Residence. No. Dayton Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 5 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hyrum Utah

PARENTS

10. NAME OF FATHER H. LeRoy McBride

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyrum Utah

12. MAIDEN NAME OF MOTHER Anna Green Welsville Utah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant LeRoy McBride
(Address) Dayton Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5-1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-30, 1930, to 5-1, 1930, that I last saw h[er] alive on 5-1, 1930, and that death occurred, on the date stated above, at 12 00 A. m.

The CAUSE OF DEATH* was as follows:
Fracture of base of Skull
Thrown out of buggy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. R. Conder, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hyrum Utah	May 3 1930

20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20554

PLACE OF DEATH

County of Franklin

City of Franklin

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

168

2. FULL NAME Samuel William Parkinson

(a) Residence. No. ~~[illegible]~~ 200 S 1 W. St. Logan, Utah
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ina Hatch

6. DATE OF BIRTH (month, day and year) Nov. 22, 1876

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheepman

(b) General nature of industry, business, or establishment in which employed (or employer) Raising sheep

(c) Name of employer Self.

9. BIRTHPLACE (city or town) Franklin
(State or country) Idaho

PARENTS

10. NAME OF FATHER Samuel C. Parkinson

11. BIRTHPLACE OF FATHER (city or town) St. Louis
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER M. Hobbs

13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country) England

14. Informant H. J. Hatch
(Address) Logan, Utah

15. Filed , 19 A. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 — 20 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-17, 1930, to 5-20, 1930

that I last saw him alive on 5-20, 1930

and that death occurred, on the date stated above, at 2 10 a m.

The CAUSE OF DEATH* was as follows:

Lysol poisoning (Manic depressive)

Suicide - Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lysol was pumped from stomach

(Signed) A. R. Cutler, M. D.

5-20, 1930 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Franklin Cemetery	5/23/30 19

20. Undertaker	Address
[illegible]	Logan Ut

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70555

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

105

2. FULL NAME Jack Card Chatterton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mona Patterson

6. DATE OF BIRTH (month, day and year) Dec. 14, 1902

7. AGE: 27 Years 27 Months 5 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mgr Retail Dept. Store
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J.C.Penney Co.

9. BIRTHPLACE (city or town) Preston
(State or country) Idaho

PARENTS

10. NAME OF FATHER Wilford C.Chatterton
11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Card
13. BIRTHPLACE OF MOTHER (city or town) Logan
(State or Country) Utah

14. Informant J. L. Packard
(Address) Preston, Idaho

15. Filed , 19 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 3-1, 1929, to 5-26, 1930
that I last saw him alive on 5-26, 1930
and that death occurred, on the date stated above, at 11 15 a m.
The CAUSE OF DEATH* was as follows:
Attack of Asthma
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Asthma
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Cemetery
Date of Burial: May 29 1930

20. Undertaker: G. W. Lindquist
Address: Logan

FORM V. S. No. 5—A—25 M.—1-19.

RECEIVED JUN 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 70552
Registered No. 50

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Elwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March 26 (Month) (Day) 1857 (Year)

7. AGE: 73 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tin Smith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Birmingham England

10. NAME OF FATHER: Isaac Elwell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Whittall

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Elwell
(Address) 518 E Center St Logan Utah

15.
Filed ..... 19.....
A. R. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to May 21 1930
that I last saw him alive on May 20 1930
and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis and General debility.
(Duration) 5 Yrs. — mos. — ds.
Contributory (Secondary) Septicaemia
(Duration) — yrs. 2 mos. — ds.

(Signed) J. W. Stalker M. D.
5/27 1930 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah
DATE OF BURIAL: 5-25-1930

20. UNDERTAKER: John M. Richards
ADDRESS: Logan, Utah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12585

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

1090

2. FULL NAME Hesy Quail Beckstead

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	7	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Preston

PARENTS

10. NAME OF FATHER: Hesy Beckstead

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Preston

12. MAIDEN NAME OF MOTHER: Delia Quail

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan Utah

14. Informant: Hesy Beckstead
(Address): Preston

15. Filed , 19 . Registrar: G. R. Curtis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-10, 1930, to 5-11, 1930
that I last saw h— alive on 5-11, 1930
and that death occurred, on the date stated above, at 11 30 m.
The CAUSE OF DEATH* was as follows:
Retro pharyngeal abscess
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. R. Curtis, M. D.
5-15, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney Idaho	May 15 30

20. Undertaker	Address
M. W. Hendricks	Preston

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20559

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 44

(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Cody

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
				hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Baby

(c) Name of employer

9. BIRTHPLACE (city or town) Preston Ida
(State or country)

PARENTS

10. NAME OF FATHER Roger Cody

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Winnemucca Nev.

12. MAIDEN NAME OF MOTHER Eva Lucile Biddle

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Logan Ut.

14. Informant Roger Cody
(Address) Preston Ida

15. Filed May 9, 1930 A. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 2, 1930
that I last saw her alive on May 2, 1930
and that death occurred, on the date stated above, at 9:30 m.
The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. Cutler, M. D.
5-3, 1930 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston Ida	5-4 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20559

PLACE OF DEATH
County of Ada
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No. 131

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Franklin Thorp Baeye

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Baeye

6. DATE OF BIRTH (month, day and year) Sept 27-1846

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	—	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kankakee Illinois

PARENTS

10. NAME OF FATHER John T. Baeye
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER De Lana Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Dora B Baeye Titus
(Address) Emmett Idaho

15. Filed 5/17, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 15, 1930
that I last saw ~~him~~ alive on May 15, 1930
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Uraemia - due to kidney failure from back pressure from bladder - obstructed Urethra (duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Enlarged Prostate (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L M Cummings, M. D.
5/17, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	5/18 1930

20. Undertaker C D Bucknum Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20560

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Lillian Frances Gardner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Alonzo Seymore Gardner

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hastings Nebr

PARENTS

10. NAME OF FATHER Edward Holmes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Eliza Midgerley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Emma L. Hopper.
(Address) Gold Bar, Washington.

15. Filed May 2, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15, 1930, to May 1, 1930
that I last saw her alive on Apr 30, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Toxemia Eclampsia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) L. M. Cummins M. D.
May 3, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 5/4 1930

20. Undertaker: C. D. Buchanan — Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7065

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No.
Primary Registration District No.
Local Registrar's No. 113
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Campbell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE	Years	Months	Days	If LESS than 1 day,
	64			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant
(Address)

15. Filed 5/19, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20, 1930, to May 17, 1930
that I last saw h[illegible] alive on May 17, 1930
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
5/19, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Ida	5/19 1930
20. Undertaker	Address
C. D. Buckmun	Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 2052

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leo Frank Holman

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9-1924

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett Idaho
(State or country)

PARENTS

10. NAME OF FATHER A. H. Holman
11. BIRTHPLACE OF FATHER (city or town) Xenia Illinois
(State or Country)
12. MAIDEN NAME OF MOTHER Cora Ann Wellman
13. BIRTHPLACE OF MOTHER (city or town) Sheridan Wyoming
(State or Country)

14. Informant A. H. Holman
(Address) Emmett Idaho

15. Filed 5/26, 1930 J. L. Reynolds
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
accidently drowned
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. L. Reynolds, M. D.
5/26, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	May 27 1930

20. Undertaker O. Bucknum — Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70563

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

185

2. FULL NAME Amanda Jane Starr

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Starr

6. DATE OF BIRTH (month, day and year): Mar 6-1843

7. AGE: 87 Years, Months: 2, Days: 21. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: Dolph
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Mrs W M Deaton
(Address): Emmett Ida

15. Filed 5/28, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1924, to May 27, 1930
that I last saw her alive on May 11th, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Results of a fractured thy and old age
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
5/28, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 5/29 1930

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUN 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. , St.)

File No. 70561

Registered No. 132

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E. Leeper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March (Month) 27 (Day) ~~1930~~ 1860 (Year)

7. AGE: 70 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Hence Wells

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Elizabeth Forrest

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nova Bevington

(Address) Nampa Ida

15. Filed 5-31 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

57

16. DATE OF DEATH: May (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1930, to May 30 1930 that I last saw her alive on 5-30-1930 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 8 Yrs. mos. ds.

Contributory (Secondary) Acidosis & Coma

(Duration) yrs. mos. 5 ds.

(Signed) J H Cromwell M. D.

5/31 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding Ida

DATE OF BURIAL: June 1 1930

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7056

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. 90)
Local Registrar's No. 298

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jackson T. Wills

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Wills

6. DATE OF BIRTH (month, day and year) March 30-1870

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Joplin - Iowa

PARENTS

10. NAME OF FATHER Not-obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not-obtainable

12. MAIDEN NAME OF MOTHER Not-obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not-obtainable

14. Informant Margaret Wills
(Address) Kooskia - Idaho

15. Filed May 28 1930 J.M. Verbeek Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to May 27, 1930
that I last saw him alive on May 27, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart-disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J.M. Verbeek M. D.
May 28, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kooskia Cemetery	May 29 1930
20. Undertaker	Address
Geo Robertson	Kamiah Idaho

RECEIVED JUN 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70566

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 297

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Alexander Hayes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Hayes

6. DATE OF BIRTH (month, day and year)

7. AGE 78 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER not - obtainable.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not - obtainable
12. MAIDEN NAME OF MOTHER Deborah Isaac
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Alice Hayes Parsons
(Address) Kimiah - Idaho

15. Filed May 18, 1930 J. M. Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 16, 1930
that I last saw him alive on May 16, 1930
and that death occurred, on the date stated above, at 1:30 p.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verberkmoes, M. D.
May 18, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sarah Miller Ranch
Date of Burial: May 19 1930

20. Undertaker: Geo Tenney
Address: Kooskia - Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

705-66

1 PLACE OF DEATH
County Idaho State Idaho Registered No.
Township or Village Kooskia or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Alexander Hayes
(a) Residence. No. Kooskia St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hayes

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE: Years 74 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kamiah Idaho

PARENTS
10 NAME OF FATHER: Wees lah koats tse tin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kamiah Idaho
12 MAIDEN NAME OF MOTHER: Deborah Hayes
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kamiah Idaho

14 Informant: Corbett B. Lawyer
(Address) Lapwai Idaho

15 Filed 5/16/, 1930 L A Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16" 1930

17 I HEREBY CERTIFY, That I attended deceased from ----, 19---, to ----, 19---,
that I last saw h---- alive on ----, 19---,
and that death occurred, on the date stated above, at ---- m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
---- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY (SECONDARY) ----
---- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ----, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Kamiah Cemetery
DATE OF BURIAL: May 19 1930
20 UNDERTAKER: Geo. W. Trenary
ADDRESS: Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 98

FORM V. S. No. 5-25 M. 1-19 RECEIVED JUN 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Green Creek

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 70567

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia Baerlacher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1840 (Year)

7. AGE: 89 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Joseph Meamer

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Durof

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Father Baerlacher

(Address) Green Creek Ida.

15. Filed 6/2 1930 N. F. Orr J. B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1929, to May 10 1930 that I last saw her alive on Jan 25 1930 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) ..... Yrs. 7 mos. ..... ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Nealy F. Orr M. D.

5/12 1930 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greencreek Cemetery

DATE OF BURIAL: 5/13 1930

20. UNDERTAKER: Vassar Und Co By Glenn Arlor.

ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

PLACE OF DEATH

County of Idaho

City of Cottonwood

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 105

Primary Registration District No. 2183

DO NOT WRITE IN THIS SPACE

State File No. 70568

Local Registrar's No. 5

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1006

2. FULL NAME Adam John Maurer

(a) Residence. No. Cottonwood Ida. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Augusta Maurer

6. DATE OF BIRTH (month, day and year) May 10 - 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
	69		11	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Creamery man.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Christian Maurer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Katherine Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Augusta Maurer

(Address) Cottonwood, Ida.

15. Filed 6/2, 1930 H. F. Orr D.R. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 20, 1930, that I last saw him alive on May 20, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Chronic Myocarditis - 3 yrs duration.
Under my care 2 days duration.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? non

(Signed) H. A. Woodcock, M. D.

5-21-, 1930 (Address) Cottonwood, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
May 23 to Dillon Mont.	19
20. Undertaker	Address
Vassar Bo.	Lewiston Ida.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20569

Local Registrar's No. 17

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. FULL NAME Mary Elizabeth Riggs

(a) Residence. No. Grangeville Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dr. H. V. Riggs

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER H. C. Beainard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Margaret Brewer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Dr H. V. Riggs
(Address) Grangeville Ida

15. Filed 5-31-, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. ds.
CONTRIBUTORY Arteriosclerosis
(Secondary)
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? High Arterial tension

(Signed) B. Chipman M. D.
5/28-, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
P. V. Cemetery	5/30 1930
20. Undertaker	Address
Vasa	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70520

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. Weber Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

49

2. FULL NAME James R. Dean
(a) Residence, No. Golden Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): ~~Single~~ Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single
6. DATE OF BIRTH (month, day and year)
7. AGE: 50 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kentuckey

PARENTS
10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentuckey
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentuckey

14. Informant: D. E. Steiner
(Address) Golden Idaho
15. Filed 5-31-, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month), 24 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 19, 1929, to May 24, 1930
that I last saw him alive on May 24, 1930
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma Gastric
(duration) 1 yrs. 2 mos. 5 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J P Weber, M. D.
May 24, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grangeville — Date of Burial: 5/25 1930
20. Undertaker: Vassar — Address: Grangeville

RECEIVED OCT 6 1930

435. 12th Ave. East.
Calgary.
Alberta.
Canada

705-70

Sept. 26th/1930.

To/ Registrar of Deaths,
Dept of Public Welfare.
Boise Idaho.

Dear Sir

Would you Kindly send me a Death Certificate, certifying the death of my husband, James Dean who died in the Webber Hospital at Grangeville Idaho on the 24th of May 1930. The Adjt of the Grangeville post informs me that all records are stored in your office. It is necessary that I have a Death Certificate, so as to establish claim for a pension, Enclosed find $2 for same if not sufficient will send balance, or pay Postman on receipt of Certificate.

Hoping you can send it as soon as possible.

I remain

Yours Truly
Mrs J. Dean.

AUG 18 1969

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70571

PLACE OF DEATH
County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 15

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alexander William Robinson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie D Robinson

6. DATE OF BIRTH (month, day and year) June 1839

7. AGE	Years	Months	Days	If LESS than 1 day,
	90	3	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER S Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant M. A. Robinson
(Address) Grangeville Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 , 1927, to April 26 , 1930
that I last saw h alive on April 26 , 1930
and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH was as follows: Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Microscopic Findings

(Signed) B Chipman , M. D.
5-1- , 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	4-28- 1930
20. Undertaker	Address
Hancock Mfg. Co	Grangeville

N. B.—Every item of information should be carefully supplied. Age should be stated RATIONALLY should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70572

PLACE OF DEATH
County of Kootenai
City of Worley R.1

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

2. FULL NAME Charles B. West. 131

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Do not know

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Chicago Ill.

PARENTS

10. NAME OF FATHER Does not know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant John O'Hara
(Address) Worley R1

15. Filed May 2, 1930 H W Shymock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 1, 1930
that I last saw h[im] alive on May 1, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Uremia.
(duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY ~~Cancer~~ 6 hrs
(Secondary)
Cutaneous burns (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? lived - (26½ hrs)
Did an operation precede death? No Date of —
Was there an autopsy? No —
What test confirmed diagnosis? —
(Signed) H W Shymock, M. D.
May 2, 1930 (Address) Harrison.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida.	5-3 1930

20. Undertaker Cassedy Funeral Home Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7055 3

Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 7

PLACE OF DEATH

County of Kootenai
City of Harrison
(Kamms Bay)
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Robert Sexton

(a) Residence No. Kamms Bay St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929-4-10

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	1	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Baylor Mich

PARENTS

10. NAME OF FATHER Jack Sexton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Laura Addington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Jack Sexton
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Accidental drowning
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18. Where was disease contracted? If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
(Address)

Got information from C.A. McDonald
Saw him with the Permanian Funeral Home
Saw body in the Funeral Home
C. Wendt

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida.	5-12 1930

20. Undertaker Cassedy Funeral Home | Address Harrison Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70574

PLACE OF DEATH

County of Kootenai
City of Athol

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 64

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1890

2. FULL NAME Rosa Alma Grater

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred about 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank E. Grater

6. DATE OF BIRTH (month, day and year) September 22 1890

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	6	15	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Appleton Wisconsin

PARENTS

10. NAME OF FATHER William Holder

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Rosa Frey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Albert G. Holder
(Address) Athol Idaho R. #1

15. Filed May 5, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 7. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7.40 a. m.
The CAUSE OF DEATH* was as follows: The automobile in which she was riding was struck at grade crossing near Athol Ida. by N. P. Ry. Passenger train, she was thrown some distance head crushed, body mangled, death was instantaneous.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Kramer, M. D.
4/8, 1930 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Athol Ida	4-9 1930
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7055

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 65

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Muriel Williams

(a) Residence. No. 308 Lyndon St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1926 10-21

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	6	14	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER Leo Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vernwood Wis.

12. MAIDEN NAME OF MOTHER Mabel Thornton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clintonville Wis.

14. Informant Oliver Williams
(Address)

15. Filed May 7, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 5, 1930.
that I last saw her alive on May 5, 1930
and that death occurred, on the date stated above, at 1.45 P. m.
The CAUSE OF DEATH* was as follows:
Burned - Accidentals
Gross fire.
Duration - 4 hrs.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination

(Signed) H. J. Sturges M. D.
May 7 - 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest. Cem. CdAlene	5-7 1930
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70516

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

4 8 B

2. FULL NAME Chas. V. Sweeney
(a) Residence. No. #3. Coeur d'Alene ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Adaline Sweeney

6. DATE OF BIRTH (month, day and year) 1854-6-15

7. AGE Years 75 Months 6 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shipping Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chippewa Falls Wis.

PARENTS
10. NAME OF FATHER Symian Sweeney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Elizabeth Taylor.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Florence Sweeney Son
(Address)

15. Filed May 7, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1929, to May 1, 1930
that I last saw him alive on May 1, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic myocardial degeneration

3 yrs. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John D. Wood, M. D.
May 2 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. C D Alene — Date of Burial: 5-6 1930

20. Undertaker: Cassedy Funeral Home — Address: C D Alene.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7057

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 68
(No. 74 a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna L. Canfield
(a) Residence. No. 15th & Montana St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel H. Canfield

6. DATE OF BIRTH (month, day and year) 1848-6-27

7. AGE	Years	Months	Days	If LESS than 1 day,
	81	10	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Galena Ill
(State or country)

PARENTS

10. NAME OF FATHER — Fowler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary E. Drane
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass.

14. Informant Harry E Canfield
(Address)

15. Filed May 7, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to May 2, 1930
that I last saw h.er alive on May 2, 1930
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Cardiac Decompensation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination
(Signed) E L Bohn M. D.
May 3, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: La Grande Ore. — Date of Burial: 5-5 1930
20. Undertaker: Cassidy Funeral Home — Address: C'd'A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70578

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 20
Primary Registration District No. 1050
Local Registrar's No. 69

(No. 440)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Millie E. Russell

(a) Residence. No. 1015 Coeur d'Alene Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Russell deceased

6. DATE OF BIRTH (month, day and year) 11-20 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Ben Spencer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant Donald Russell
(Address) Coeur d'Alene Ida

15. Filed 5/29, 1930 N. L. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to May 23, 1930.
that I last saw her alive on May 23, 1930.
and that death occurred, on the date stated above, at 12:15 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical signs
(Signed) E L Spokes, M. D.
May 25, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	May 25 1930
20. Undertaker	Address
T. B. Mooney	Coeur d'Alene

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70599

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

44 B

2. FULL NAME Sarah A. Young

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Stewart Young

6. DATE OF BIRTH (month, day and year) 1845 1-27

7. AGE Years 85 Months 3 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newfield N.Y.

PARENTS
10. NAME OF FATHER Jas. Colgrove
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Newfield N.Y.
12. MAIDEN NAME OF MOTHER Mary Brooks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant A. O. Skinner
(Address) Rathdrum Ida.

15. Filed 5/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 22. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to May 22, 1930
that I last saw her alive on May 22, 1930
and that death occurred, on the date stated above, at 10.00 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
about 1 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wenz, M. D.
5/23, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Fairmont Cem. Peace Abbey, Spokane
Date of Burial 5-26-1930

20. Undertaker Cassady Funeral Home
Address C. Saline Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 705

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 71

PLACE OF DEATH
County of Kootenai
City of Rathdrum
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Muriel Francis Monaghan 9

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 3-17

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	2	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Spokane Wash.
(State or country)

PARENTS

10. NAME OF FATHER Patrick E. Monaghan
11. BIRTHPLACE OF FATHER (city or town) Mich.
(State or Country)
12. MAIDEN NAME OF MOTHER Selah Ernsberger
13. BIRTHPLACE OF MOTHER (city or town) Ore.
(State or Country)

14. Informant P. E. Monaghan
(Address)

15. Filed 5/29, 1930 H. J. Sturger
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11. 1930, to May 23. 1930
that I last saw h[illegible] alive on May 23. 1930
and that death occurred, on the date stated above, at 4.15 P. m.
The CAUSE OF DEATH* was as follows:
Whooping Cough and Bronchitis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Acute Indigestion
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Wray M. D.
5/24. 1930. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cem. Rathdrum	5-28 1930

20. Undertaker Parsed Funeral Home Address Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70581

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 72

(No. Home Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Susan Gertrude Carder

(a) Residence. No. Coeur D' Alene Ida. R. F. D. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph E. Carder

6. DATE OF BIRTH (month, day and year) March 7, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	3	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Alvin Barrier

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Harper

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14. Informant Joseph E. Carder,
(Address) Coeur D' Alene, Ida. R. D.

15. Filed 5/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 26, 1930
that I last saw h[illegible] alive on May 24, 1930
and that death occurred, on the date stated above, at 1 [illegible] m.
The CAUSE OF DEATH* was as follows:

Central Lemorrhage

(duration) — yrs. 9 mos. 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. C. Myer, M. D.
May 25, 1930 (Address) Coeur d Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	May 27 1930

20. Undertaker P. D. Mooney Address Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7068

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 73

PLACE OF DEATH
County of Kootenai
City of

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August Fischbacker

(a) Residence. No. Near Hauser Lake St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1848

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Coroners Office
(Address) Coeur d Alene Idaho

15. Filed 5/29, 1930 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Found dead in Bed. had been dead for several days
(Probably Heart disease)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [illegible] M. D.
June 2, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rathdrum Cemetery	6-2 1930
20. Undertaker	**Address**
Carey Funeral Home	C. D'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70583

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 3e
Primary Registration District No. 1050
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

74a

2. FULL NAME Catherine Swanson
(a) Residence. No. 515 - W. Summit St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Swanson
6. DATE OF BIRTH (month, day and year) 1857 7-16
7. AGE Years 72 Months 7 Days 16 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Daniel Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Swenden
12. MAIDEN NAME OF MOTHER Anna —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Olive Hoffman
(Address)
15. Filed 5/29, 1930 H. L. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 27 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to May 26, 1930
that I last saw her alive on May 26, 1930
and that death occurred, on the date stated above, at 12 10 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis - Gastric Carcinoma (duration) Not yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Dwyer M. D.
May 29, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 5-30 1930
20. Undertaker Cassedy Funeral Home — Address C D Alene Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 705[illegible]

PLACE OF DEATH
County of Kootenai
City of Hayden Lake

Registration District No. 30
Primary Registration District No. 1058
Local Registrar's No. 75
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mary Jean Libby

(a) Residence. No. ..... St. Valley Ford, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 15 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 18, 1863

7. AGE Years 66 Months 7 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ont. Canada

PARENTS

10. NAME OF FATHER Andrew Nevin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Gilmore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant C. V. Spencer
(Address) Hayden, Lake, Idaho.

15. Filed 5/29, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 7, 1930
that I last saw her alive on May 6, 1930
and that death occurred, on the date stated above, at 4:15 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease
..... (duration) unknown yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Wenz, M. D.
5/9, 1930. (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial May 9, 1930

20. Undertaker R. B. Mooney Address Coeur d'Alene

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20585

PLACE OF DEATH
County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Elizabeth Paulson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan. 20 1851

7. AGE: Years 79 | Months 3 | Days 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Erik Paulson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Anna —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: M Paulson
(Address): Troy Idaho

15. Filed May 31, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 15, 1930
that I last saw her alive on May 11, 1930
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo. A. Meyer, M.D.
, 19 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dry creek cemetery	May 18 1930
20. Undertaker	Address
John J. Pickerd	Troy Idaho

d.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH
County of Latah
City of (Near) Troy

Registration District No. 64
Primary Registration District No. 2144
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 129

2. FULL NAME Annie Snoen

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred 16 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? 57 yrs. .... mos. .... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elling H. Snoen

6. DATE OF BIRTH (month, day and year) June 1, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	59	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Arnt Dumbu
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Annie Dumbu
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant John Snoen
(Address) Troy Ida

15. Filed May 31 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to May 1, 1930
that I last saw her alive on April 26, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows: Chronic Nephritis.

(duration) 7 yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 2 yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of ....
Was there an autopsy? No
What test confirmed diagnosis? ....
(Signed) Chas G. Meyer, M. D.
5/1, 1930 (Address) Troy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	5/5 1930

20. Undertaker H. R. Short
Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7053?

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

1010

2. FULL NAME Austin Walfred Nelson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 18 1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Troy Ida

PARENTS
10. NAME OF FATHER August Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Matildia Hedberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs August Nelson
(Address) Troy Ida

15. Filed May 31, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 25, 1930, to May 1st, 1930
that I last saw him alive on May 1st, 1930
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. A. Meyer M. D.
5-3-, 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kestdala cemetery	May 4 1930
20. Undertaker	Address
John J. Pickerd	Troy Ida.

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7068

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

164

2. FULL NAME August Lisching
(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Gust Shoberg
(Address) Deary Ida.

15. Filed May 31, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to May 13, 1930.
that I last saw h[illegible] alive on May 13, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M. D.
May 14, 1930 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Texas Ridge cemetery	May 15 1930
20. Undertaker	Address
John J. Pickard	Troy Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70589

PLACE OF DEATH
County of Latah
City of Julietta

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 205 B

2. FULL NAME Thomas Stinson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Grace Albert Stinson

6. DATE OF BIRTH (month, day and year) Apr. 29 - 1859

7. AGE Years 70 Months 11 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tuscalosa Co Mich

PARENTS
10. NAME OF FATHER William Stinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Eliza Brophy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Grace Albert Stinson
(Address) Julietta, Idaho

15. Filed April 19, 1930 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never, 19, to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at 8:30 p m.
The CAUSE OF DEATH* was as follows:
Unknown - prob.
Heart disease (2) or apoplexy (?)
Died in presence of Mrs. Stinson quietly (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Field, M. D.
Apr. 18, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho — Date of Burial April 20 1930

20. Undertaker H. R. Merchant — Address Clarkston, Wn

RECEIVED MAY 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH
County of Latah
City of Pot Latch

CERTIFICATE OF DEATH
Registration District No. 5
Primary Registration District No. 2145 Local Registrar's No.
(No. Western Hospital Association, Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

91 B

2. **FULL NAME** Fredrick J Beyer.
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 28/1849

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10. NAME OF FATHER G. Beyer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) L. O. Beyer Diary Ida

15. Filed May 9th 1930 D. Jw. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to May 8th, 1930
that I last saw him alive on May 8th, 19
and that death occurred, on the date stated above, at 2:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. C. Gibson, M. D.
May 9th, 1930 (Address) Pottatch

19. Place of Burial, Cremation, or Removal: Elwood Cem
Date of Burial: May 11 1930

20. Undertaker Diary Ida, E. M. Trum Palouse Wash.
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED MAY 22 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Potlatch

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 70[illegible]

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Still birth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: April (Month) 28 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Potlatch

10. NAME OF FATHER: Nels. Opstrup

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Nancy. Asplund

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nels. Opstrup

(Address) Potlatch

15. Filed April 28 1930

D. Jr. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1930 (Year)

161a

17. I HEREBY CERTIFY, That I attended deceased from April 28th 1930, to April 28th 1930

that I last saw him alive on April 28th 1930

and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) /

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F C. Gibson. M. D.

4/28/1930 (Address) Potlatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: April 29 1930

20. UNDERTAKER: Parents — ADDRESS: Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH

County of Latah

City of Genesee

Registration District No. 62

Primary Registration District No. 2142

Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME William Jackson Ryker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of California Ryker

6. DATE OF BIRTH (month, day and year) Dec. 13, 1845

7. AGE Years 84 Months 5 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known Indiana

PARENTS

10. NAME OF FATHER Jerrod Ryker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Mary Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant R. Bell
(Address) Genesee Ida

15. Filed May 24, 1930. W. H. Ehlers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:
Saw him after was dead
Evidently some kind
of heart disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) W. H. Ehlers, M. D.

May 23, 1930 (Address) Genesee Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 5/26/30 19

20. Undertaker: H. R. Short

Address: Moscow

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Genesee

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62

Primary Registration District No. 242

(No. ..... St.)

File No. 70503

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evangeline Haggerty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1904 (Year)

7. AGE: 25 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Genesee Idaho

10. NAME OF FATHER: Jno Gehrke

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Pauline Ertman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hugo A Gehrke

(Address) Genesee Idaho

15. Filed Apr 17 1930 W H Ehlen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1930 (Year)

31

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1930, to Apr 17 1930, that I last saw her alive on Apr 17 1930, and that death occurred on the date stated above, at 12 (a) M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Ehlen M. D.

4-17 1930 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Genesee Idaho

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho

DATE OF BURIAL: 4/19 1950

20. UNDERTAKER: Brower-Wann Co.

ADDRESS: Lewiston, Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7654

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack Ryan

(a) Residence. No. Salmon Idaho County Farmer St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE: Years 83 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: County Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Salmon Idaho
(Address): Jno C Doebele

15. Filed May 1 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 15th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1929, to Apr 15, 1930, that I last saw h[im] alive on Apr 15, 1930, and that death occurred, on the date stated above, at 7-15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs 15 mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Chas F Hammer, M. D.
May 6, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	4-15th 1930
20. Undertaker	Address
Jno C Doebele	Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7615

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

49

2. FULL NAME Alice Isabel McDonald

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 48 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. 47 mos. 4 ds. 22

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female		Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John McDonald

6. DATE OF BIRTH (month, day and year) July 1, 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Homemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Toronto, Canada

PARENTS

10. NAME OF FATHER Daniel Kane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Elizabeth Baird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Edinburgh Scotland

14. Informant James McDonald
(Address) Salmon Idaho

15. Filed May 1, 1930. Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 31, 1930
that I last saw her alive on March 15, 19
and that death occurred, on the date stated above, at 4-30 A. m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) High Blood pressure
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F S Wright, M. D.
4/30, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	4-3" 1930
20. Undertaker	Address
J M C Noebles	Salmon Ida.

RECEIVED APR 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. County Poor Farm)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

45

2. FULL NAME William - Moody

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): American

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: Wm C Doebler
(Address) Salmon Idaho

15. Filed May 10, 1930 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to March 19, 1930
that I last saw him alive on March 19, 1930
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of rectum & bullocks -
Several years (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
May 6, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon | Date of Burial: Mar 25 1930

20. Undertaker: Wm C. Doebler | Address: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7067

Registration District No. 41
Primary Registration District No. 2116
Local Registrar's No. 169

PLACE OF DEATH

County of Lemhi
City of Salmon
State of Idaho.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles A Devlan

(a) Residence. No. Governor Hotel, San Francisco, Cal St. San Francisco, Cal.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. a transient here How long in U. S., if of foreign birth? Native born

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of E. H. Devlan, Wife.
at Governor Hotel, San Francisco, Cal.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mine Promotor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer He was President of Montana Mining & Live Stock Co a corporation

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Unknown here
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown here
12. MAIDEN NAME OF MOTHER Unknown here
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown here

14. Informant John H. Padgham
(Address) Salmon, Idaho.

15. Filed June 10, 1930 Chas C. Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on May 17, 1930
and that death occurred, on the date stated above, at 8.30 A m.
The CAUSE OF DEATH* was as follows:
Suicide by drowning in Salmon River at the City of Salmon, Idaho.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis?

(Signed) Jno C. Noble Coroner, ~~M. D.~~
May 29th, 1930 (Address) Salmon Idaho,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portland Creamatory Portland, Oregon.	19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH

County of Lewis
City of Gaymont

Registration District No. 30
Primary Registration District No. 2179
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

74a

2. FULL NAME Wilma E Brown

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 22 1894

7. AGE: 35 Years | Months: 5 | Days: 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Uniontown Wash

PARENTS

10. NAME OF FATHER: E S Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mich
12. MAIDEN NAME OF MOTHER: Atlina Hibbs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill

14. Informant: Mrs L French
(Address) Clarkston Wash

15. Filed 6/20, 1930 R E Dwelch Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929, 19..., to May 16, 1930
that I last saw her alive on May 15, 1930
and that death occurred, on the date stated above, at 1.30 p.m.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy.
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) sercoal pyrexia [illegible] allocus
..... (duration) Sing yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual
(Signed) R E Dwelch M. D.
5/20, 1930 (Address) Gaymont Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston Wash | Date of Burial: 5/18 1930

20. Undertaker: H R Merchant | Address: Clarkston Wash

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70600

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 2016
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44 A

2. FULL NAME Willard Melvill Fields

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~~Pete~~ Emma Fields

6. DATE OF BIRTH (month, day and year) Sept 5 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	8	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Delhi (State or country) Iowa

PARENTS

10. NAME OF FATHER Thos. J. Fields

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Helen Whitcomb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Emma Fields
(Address) Shoshone Idaho

15. Filed May 24, 1930 H. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1930, to May 23 1930
that I last saw him alive on May 23, 1930
and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(Rheumatic)
(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. B. Gaufin M. D.
5-24-1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	5-25 1930
20. Undertaker	Address
C. E. Hickok	Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. [illegible]

County Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 70601

Local Registrar's No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: June (Month) 7. (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 19 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Premature.
(b) General nature of industry, business or establishment in which employed (or employer): Rexburg Idaho

9. BIRTHPLACE (State or Country)

10. NAME OF Father: Albert Allen

11. BIRTHPLACE OF FATHER (State or Country): Coalville Utah

12. MAIDEN NAME OF MOTHER: Katie Rouecke

13. BIRTHPLACE OF MOTHER (State or Country): Kaysville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorin F. Rich
(Address) Rexburg Ida.

15. Filed 6/8 1930 J. V. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1930, to June 8 1930, that I last saw him alive on June 8 1930, and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Premature birth. (not viable)
Nephritis of Mother, who died 6/7/30
(Duration) ..... yrs. ..... mos. One ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin F. Rich M. D.
6/8 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 1 ds.
Where was disease contracted if not at place of death? .....
Former or usual residence St Anthony Idaho.

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

JUN 14 1930

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. .....

Local Registrar's No. 28

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katie Roueche Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word)

6. DATE OF BIRTH: March (Month) 15 (Day) 1893 (Year)

7. AGE: 37 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kaysville Utah.

10. NAME OF Father: Francis Roueche

11. BIRTHPLACE OF FATHER (State or Country): Kaysville Utah

12. MAIDEN NAME OF MOTHER: Helen Merridith

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorin F. Rich.
(Address) Rexburg Idaho,

15. Filed 6/7 1930 J. Cyoung Local Registrar

MEDICAL CERTIFICATE OF DEATH

46

16. DATE OF DEATH: June (Month) 7. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1930, to June 7 1930, that I last saw her alive on June 7 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of ovary
Left. primary.
(autopsy findings.)
(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis. Premature birth of baby.
(Duration) ..... yrs. ..... mos. ..... ds.

6/7 (Signed) Lorin F. Rich M. D.
1930. (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State 36 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? St Anthony Idaho,
Former or usual residence St Anthony Idaho,

19. PLACE OF BURIAL OR REMOVAL: St Anthony Ida.

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wm M Hansen

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUN 14 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Burton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 70602

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud Jones (Infant)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June 5th (Month) (Day) 1930 (Year)

7. AGE: 12 Hours ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Burton Ida

10. NAME OF FATHER: Ralph R Jones

11. BIRTHPLACE OF FATHER (State or Country): Monida Montana

12. MAIDEN NAME OF MOTHER: Ada Brothers

13. BIRTHPLACE OF MOTHER (State or Country): Mariesville Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph R Jones

(Address) Rexburg # 1.

15. Filed 6/8 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: June (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-5 1930, to 6-6 1930 that I last saw her alive on 6-5 1930 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

6-6 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City.

DATE OF BURIAL: June 7 1930

20. UNDERTAKER: Vern J. Keller

ADDRESS: Rexburg Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. [illegible] RECEIVED JUN 14 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Madison

City of Thornton.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

State File No. 70604

Local Registrar's No. 26

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Kington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6. DATE OF BIRTH: 6 (Month) 3 (Day) 1930 (Year)

7. AGE: None — Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF Father: Thomas Kington

11. BIRTHPLACE OF FATHER (State or Country): Cache ~~Valley~~ Co Utah

12. MAIDEN NAME OF MOTHER: Bessie Rocks

13. BIRTHPLACE OF MOTHER (State or Country): Cache Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Kington
(Address) Thornton Ida

15. Filed 6/4 1930 J. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

206

16. DATE OF DEATH: 6 (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-3-1930, to 6-3-1930, that I last saw her alive on 6-3-1930, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Premature birth 6th Month. Not viable.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

6/3 1930 (Signed) Louis X. Rich M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL ..... 19....

20. UNDERTAKER: — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

181486 +

RECEIVED JUN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70805

PLACE OF DEATH

County of Sugar City

City of Madison

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Fawn Christian Murdock

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 4th-1917

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	3	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (School)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sugar City-Idaho

PARENTS

10. NAME OF FATHER Alva N. Murdock

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Sarah C. Larsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Alva N. Murdock
(Address) Sugar City-Idaho

15. Filed May 25, 1930 J Reyonng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to May 22, 1930

that I last saw him alive on May 22, 1930

and that death occurred, on the date stated above, at 2:a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
parenchymatous

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? place of death

Did an operation precede death? no Date ✓

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings & symptoms

(Signed) Lorin I. Rich, M. D.

May 24, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City Cemetary	19

20. Undertaker	Address
Alvin Keller	Rexburg-Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 14 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 76[illegible]

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 25

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Hyrum John Lucas

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 21-1863

7. AGE: Years 67, Months 3, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: James Lucas

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Susan Harriett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. H. J. Lucas
(Address): Rexburg Ida

15. Filed May 17, 1930 J. N. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec, 1930, to May 12, 1930

that I last saw him alive on May 11, 1930

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows: Diabetis Mellitites

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Carbuncle back of Mesle (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.

May 15, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Plano City

Date of Burial: May 14 1930

20. Undertaker: Vern J. Keller

Address: Rexburg

RECEIVED JUN 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76662

PLACE OF DEATH
County of Madison
City of Rexburg Ida II
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 23
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Alphonso M. Carter.
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug. 2, 1854
7. AGE Years 75 Months 9 Days 9 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) Ranching
(c) Name of employer Self
9. BIRTHPLACE (city or town) (State or country) St. Maris Providence of Quebeck.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. M. C. Truxell.
(Address) Rexburg
15. Filed 5/15, 1930 J. Byorng Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to May 11, 1930
that I last saw him alive on May 11, 1930
and that death occurred, on the date stated above, at 3:30 A. m.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. Sutherland, M. D.
5-13, 1930 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg Ida. Date of Burial May 13 1930.
20. Undertaker Von J. Keller. Address Rexburg

...ANLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
... of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76662

PLACE OF DEATH
County of Minnewaka Acequia
City of

Registration District No. 19
Primary Registration District No. 2015
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

128

2. FULL NAME Lila Deno

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 4, Months 11, Days 18. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: William S Deno
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Clista Hunter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Mrs Clista Deno
(Address) Acequia

15. Filed 6-5, 1930 E. W. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Jan 8, 1930
that I last saw her alive on Jan. 7, 1930
and that death occurred, on the date stated above, at 2 46 A m.
The CAUSE OF DEATH* was as follows:
Acute nephritis
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? urine & other tests
(Signed) E. W. Elmore M. D.
6-10, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Cemetery
Date of Burial: Jan 10 1930

20. Undertaker: W. G. Goodman
Address: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 14

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Virginia Nutting

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
fem	white	Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 16 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	1	16	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Barton Nutting

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nellie Denney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Barton Nutting
(Address) Rupert Idaho

15. Filed 6-10, 1930 A. E. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929, to Mar 4, 1930
that I last saw h[illegible] alive on Mar. 4, 1930
and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:
Cerebrospinal meningitis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Spinal fluid
(Signed) J. B. Kenney, M. D.
5-13-, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Mar 6 1930

20. Undertaker W. O. Goodman
Address Rupert

710

RECEIVED JUN 17 1930

STATE OF IDAHO J.B.K.
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 17[illegible]

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No. .....)
Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME David A. Lewis 90

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 9 1854

7 AGE: Years 75 | Months 5 | Days 13 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Harness Maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10 NAME OF FATHER C. G. Lewis
11 BIRTHPLACE OF FATHER (city or town) (State or country) New York
12 MAIDEN NAME OF MOTHER Cintha Earl
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Della Smith
(Address) Rupert Idaho

15 Filed 6-10, 1930 Ed Ehmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to Feb. 23, 1930, that I last saw him alive on Feb. 23, 1930, and that death occurred, on the date stated above, at 12-23 m.

The CAUSE OF DEATH* was as follows:
Chronic valvular disease of heart
(duration) 1 yr yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) J B K ....., M. D.
5-13-, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery — Date of Burial: Feb 26 1930
20 Undertaker: W. J. Goodman — Address: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE K
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 70832

PLACE OF DEATH

County of Minidoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 19

101 a

2. FULL NAME Edith Mary Hartley

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) January 27 1860

7 AGE: Years 69 | Months 11 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Charles Reece

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: W. F. R. Hartley

(Address): Rupert Idaho

15 Filed 6-10, 1930 E. H. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 15 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 15, 1930, that I last saw her alive on Jan 15, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Layne H. Kenagy, M. D.

5-13, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetry

Date of Burial: Jan 20 1930

20 Undertaker: W. A. Goodman

Address: Rupert Idaho

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7683

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 20

162

PLACE OF DEATH
County of Minidoka
City of Rupert
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Baby Demo

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, 3 hrs. or min. 30

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Lester Demo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana
12. MAIDEN NAME OF MOTHER Bertha Boyd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Lester Demo
(Address) Rupert Idaho

15. Filed 6-10, 1930 E. E. Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Asphyxia neonatorum
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Faye A. Keraga, M. D.
5-13, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Feb 14 1930
20. Undertaker W. A. Goodman	Address Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Johnson

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 22 1852

7 AGE: Years 78 | Months 5 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Roy Lilly
(Address): Rupert Idaho

15 Filed 6-10, 1930 Ed E Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 26 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 25, 1930,
that I last saw him alive on Feb 24, 1930,
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis with decompensation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) Faye A. Gregg, M. D.
5-13-30 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery — Date of Burial: Feb 26 1930

20 Undertaker: W. G. Goodman — Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 2[illegible]

(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ethel Algera Yarborough

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): April 16 1905

7 AGE: Years 24 | Months 9 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10 NAME OF FATHER: Atkins Yarbrough

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Ruth Naland

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Nora Y. Sturm

(Address): Clifton Arizona

15 Filed 6-10 1930 E. W. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Ethel January 26 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 30, 1929, to Jan 26, 1930, that I last saw her alive on Jan 26, 1930, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home (?)

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Sputum positive

(Signed) Fayre H. Lenagy, M. D.

Jan 28, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Moscow Idaho

Date of Burial: Feb 2 1930

20 Undertaker: W. A. Goodman

Address: Rupert

RECEIVED JUN 17 1930

E

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70621

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 26

129

PLACE OF DEATH

County of Minidoka

City of Rupert

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Clara Rausch

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) Jan 20 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	1	19	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Kincobi Klee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Andrew Rausch

(Address) Rupert Idaho

15. Filed 3-9, 1930 E. E. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to March 8, 1930

that I last saw her alive on March 8, 1930

and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. E. Elmore, M. D.

3-9, 1930 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Monett Missouri	

20. Undertaker	Address
W. G. Goodman	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

FK

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Minidoka
City of Minidoka

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

177

2. FULL NAME Zeta Louise Rice

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 6 1900

7. AGE: Years 29, Months 8, Days 7. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: George Thurman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Anna Hartman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Rosa Thurman
(Address) Elko Nevada

15. Filed 6-10, 1930 Ett Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 13, 1930
that I last saw her alive on Feb 13, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Bichloride poisoning
Contraceptive
(duration) ..... yrs. ..... mos. 13 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? no [and history
What test confirmed diagnosis? Reuse function
(Signed) Fayre H. Kinney M. D.
5-13 1930 (Address) J. Rupert Iowa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Albion Cemetry — Date of Burial: Feb 1930

20. Undertaker: W. A. Goodman — Address: Rupert Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70023

PLACE OF DEATH
County of Minidoka
City of Paul

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No. 28
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16 2

2. FULL NAME Lamberto Ojeda

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Mexican
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 22 1930

7. AGE Years Months 2 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Ida

PARENTS

10. NAME OF FATHER Frailan Ojeda

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Mexico

12. MAIDEN NAME OF MOTHER Josejhina Guarez

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Nebraska

14. Informant Frailan R Ojeda
(Address) Paul Idaho.

15. Filed May 21, 1930 E W [illegible]
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 20, 1930
that I last saw him alive on May 1, 1930
and that death occurred, on the date stated above, at 2.15 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E H Cutler, M. D.
May 21, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal Paul Ida
Date of Burial May 21 1930

20. Undertaker D.E.JOhnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Minnedoka
City of Rupert.

Registration District No. 19
Primary Registration District No. 2017 Local Registrar's No. 29
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. **FULL NAME** Davis Merrill Green

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 8 1924

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6		15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paul Ida.

PARENTS

10. NAME OF FATHER J. Davis Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hooper

12. MAIDEN NAME OF MOTHER Clarinda M. Merrill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Richmond Utah

14. Informant J. E. Merrill Paul Ida
(Address)

15. Filed 6-10, 1930 E. E. Elmore Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 23, 1930, to May 23, 1930
that I last saw him alive on May 23, 1930
and that death occurred, on the date stated above, at 12 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Extensive burns from explosion of kerosene can
(duration) ..... yrs. ..... mos. 1 hr. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E. E. Elmore M. D.
5-31, 1930 (Address) Rupert, Ida.

19. Place of Burial, Cremation, or Removal: Paul Ida. Date of Burial: May 25 1930
20. Undertaker: D. E. Johnson Address: Burley

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7[illegible]

PLACE OF DEATH
County of Shoshone
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No. .....)
Local Registrar's No. 30

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mary E Moody

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, ~~Married~~, Widowed or ~~Divorced~~ (write the word): Widowed

5a ~~If married~~, widowed, ~~or divorced~~
HUSBAND of (or) WIFE of July 7 1856

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10 NAME OF FATHER: Jacob Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know
12 MAIDEN NAME OF MOTHER: Horn
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Mrs Neva Lewis
(Address): Rupert Idaho

15 Filed 5-25, 1930 Ed E Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 24 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to May 24, 1930, that I last saw her alive on May 22, 1930, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
..... (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) Ed E Elmore M. D.
5-25, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Silver Creek Cem | Date of Burial: May 28 1930

20 Undertaker: W. A. Goodman | Address: Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

E

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Rupert

City of Minidoka

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 31

57

2. FULL NAME William D Bohon

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 9 1872

7 AGE: Years 57 | Months 3 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10 NAME OF FATHER: James K Pake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER: Rosana Roy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Missouri

14 Informant: Frank M Bohon

(Address) Heyburn

15 Filed 6-10, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 22 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1928, to Feb. 22, 1930, that I last saw him alive on Feb 22, 1930, and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diabetis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Urine & blood

(Signed) E H Elmore, M. D.

6-10, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery

Date of Burial: Feb 25 1930

20 Undertaker: H. A. Goodman

Address: Rupert

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 79[illegible]

PLACE OF DEATH

County of Minidoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

Local Registrar's No. 33

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

101a

2. FULL NAME William Craven

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 26 1929

7 AGE Years | Months 11 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rupert Idaho

PARENTS

10 NAME OF FATHER: Emmett W Craven

11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri

12 MAIDEN NAME OF MOTHER: Ola Clevenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Missouri

14 Informant: Emmett Craven

(Address) Rupert Ida

15 Filed 6-10, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to Feb. 23, 1930, that I last saw him alive on Feb. 23, 1930, and that death occurred, on the date stated above, at 3:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Elmore M. D.

6-10, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker: W A Goodman | Address: Rupert Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

E

DO NOT WRITE IN THIS SPACE
State File No. 7669

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2815
Local Registrar's No. 34

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vivian S. Doane

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	8	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Idaho

PARENTS

10. NAME OF FATHER Chauncey Doane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Sadie R Campbell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Sarah N Campbell
(Address) Rupert Idaho

15. Filed 6-10-1930 Ed Edmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to Mar 27, 1930
that I last saw her alive on March 27, 1930
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:
Pneumonia bilateral
Influenza

(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Ether Chloroform anesthesia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 3-27-30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Ed Edmore M. D.
6-10, 1930 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Mar 29 1930
20. Undertaker	Address
W. G. Goodman	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70630

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 14
Primary Registration District No. 2015
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

2. FULL NAME Clyde F. Kloepfer

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 21 1915

7. AGE: Years 14 | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rupert Idaho

PARENTS

10. NAME OF FATHER: William H Kloepfer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Butte Montana
12. MAIDEN NAME OF MOTHER: Rachel Fuhriman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: William Kloepfer
(Address): Rupert Idaho

15. Filed 6-10, 1930 E. B. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from mar. 28, 1930, to mar. 28, 1930
that I last saw him alive on mar. 28, 1930
and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:
Puncture of lung by ribs in Automobile accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Overturned auto falling on chest

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) E. B. Elmore M. D.
6-10, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Mar 31 1930
20. Undertaker	Address
W. G. Goodman	Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7051

PLACE OF DEATH
County of Minidoka
City of Minidoka

Registration District No. 19
Primary Registration District No. 2015
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

2. FULL NAME Gangola Pine

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) March 8 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Jas Azcona
(Address) Minidoka

15. Filed 6-10, 1930 Ed E Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to April 18, 1930
that I last saw him alive on April 12, 1930
and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:
Myocarditis, arterio-sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Ed E Elmore M. D.
6-10, 1930 (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Catholic Cem	Apr 18 1930
20. Undertaker	Address
W. G. Gardeman	Rupert Idaho

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Tuesday

DO NOT WRITE IN THIS SPACE

State File No. 76632

PLACE OF DEATH

County of Minedoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 37

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ira G. Clayville

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 47 | Months 2 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10 NAME OF FATHER: Emery Clayville

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Matilda Scholl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Missouri

14 Informant: George Clayville

(Address) Portland 181 E 80 South

15 Filed 6-18, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) 17 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1927, to Jan. 17, 1930, that I last saw him alive on Dec. 18, 1929, and that death occurred, on the date stated above, at 4:40 A.m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E H Elmore, M. D.

6-10, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: W. A. Goodman | Date of Burial: Jan 23 1930

20. Undertaker: W. A. Goodman | Address: Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70633

PLACE OF DEATH

County of NezPerce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 329 6th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza Francis Bramblet. 90

(a) Residence. No. 329 6th, St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 26th, 1853.

7. AGE: Years 77. Months 1 Days 18. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER Jesse Hicks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Elizabeth Nichols.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Mrs R. L. Ragon.
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to April 14, 1930 that I last saw her alive on April 14, 1930 and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows: Organic heart disease

(duration) years yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul W Johnson, M. D.
4/15/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane, Washington. Date of Ship. 4/15/30. 19

20. Undertaker: Brower-Wann Company. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7063

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1089
(No. White's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Pearl Emma Gerlach

(a) Residence. No. 119 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 22 - 1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS

10. NAME OF FATHER Pete Smithers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Harriet Fory
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Ramona Collier
(Address) San Francisco, Calif.

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) - 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-80, 1930, to 4-16, 1930
that I last saw h[illegible] alive on 4-16, 1930
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF ~~DEATH~~* was as follows:
Acute toxaemia following Post operative Strangulation of small intestine
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Adhesions from previous Operation (duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 4-14-30
Was there an autopsy? No
What test confirmed diagnosis? Operative findings

(Signed) E. R. Collier M. D.
4/16, 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	4/17, 1930
20. Undertaker	Address
Brown-Wann Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70635

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 95 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

88a

2. FULL NAME Elma Ingaborg Pearson
(a) Residence. No. ..... St. Craigmont Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16 1912

7. AGE Years 18 Months 2 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) Normal School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Chas. A. Pearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Anghild Wreckstrom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant C. A. Pearson
(Address) Craigmont Ida

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: acute endocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of Ap 17.30
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E M Brower Coroner
4/20, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Craigmont Idaho
Date of Burial 4/21 1930

20. Undertaker Brower - Wann Co
Address Lewiston Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70030

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 1102 - 15th Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

✓ 65-a

2. FULL NAME Gordon Weaver Robison

(a) Residence. No. 1102 - 15th Ave ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1 1925

7. AGE Years 5 Months 1 Days 22 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho.

PARENTS
10. NAME OF FATHER W-M. Robison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Tresa Premus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant W-M. Robison
(Address) 1102 - 15th Ave Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 22, 1930 that I last saw him alive on April 22, 1930 and that death occurred, on the date stated above, at 9:50 A.m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. blood + Glands

(Signed) E G Braddock, M. D.

Apr 24, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial 4/24 1930

20. Undertaker Vassar Mortuary Inc. Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stockslager

DO NOT WRITE IN THIS SPACE

State File No. 70633

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 95

Primary Registration District No. 1009

Local Registrar's No.

(No. Orchards.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Jesse Dean Tallant.

(a) Residence. No. Orchards. XX.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 16th, 1929.

7. AGE Years: ------ Months: 4. Days: 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Idaho.

PARENTS

10. NAME OF FATHER Jesse Tallant.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Rabecca Armour.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas.

14. Informant Jesse Tallant
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23rd, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Apr 23, 1930

that I last saw him alive on Apr. 20, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature, Malnutrition

(duration) yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) B Stockslager, M. D.

4/24/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 4/24/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76640

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Nancy E. Platt
(a) Residence. No. Melrose, Ida St. Melrose Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12th 1850

7. AGE: Years 79, Months 9, Days 17. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not known

PARENTS
10. NAME OF FATHER: Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: G. L. Richardson
(Address) Melrose, Ida.

15. Filed Jan 1, 1930 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-23-30, 19__, to 4-29-30, 19__
that I last saw her alive on 4/29-30, 1930
and that death occurred, on the date stated above, at 3:30 p. m.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rouse M.D. M. D.
4/30, 1930 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Melrose, Idaho
Date of Burial: 5/1 1930

20. Undertaker: Brower-Wann Co
Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20611

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. Bollinger Hotel.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Charles Albert Wagner.

(a) Residence. No. St. Gifford, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 6th, 1874.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55.	7.	22.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs C. A. Wagner

(Address) Gifford, Idaho.

15. Filed June 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-29-30
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 4/28-30, 19, to 4/29-30, 19
that I last saw h~~e~~ alive on 4/29-30, 19
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH was as follows: Acute dilatation of heart,

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes. What test confirmed diagnosis? Symptoms & Physical

(Signed) J. H. Forbes, M. D.

4/29-30, 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	5/1-30 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Ida.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70049

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Forest Lee Durbin
(a) Residence. No. 607 - 10th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 5 - 1925.

7. AGE: Years 5 | Months — | Days 11 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pee El, Wash.

PARENTS
10. NAME OF FATHER Paul N. Durbin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clarkston Illinois.
12. MAIDEN NAME OF MOTHER Florence Beach.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas City Kansas.

14. Informant Paul N. Durbin
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 16th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 16, 1930
that I last saw him alive on Feb 16, 1930
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Flu Pneumonia;
Rt Lobar Pneumonia,
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Flu
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symp & X Ray.
(Signed) E. L. White M. D.
2/18, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho
Date of Burial: 2/18 1930
20. Undertaker: Brower - Wann E
Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20643

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No. 124
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Nez Perce
City of Lewiston

2. FULL NAME Owen Nugent
(a) Residence. No. Gifford Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) not known

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranches.
(b) General nature of industry, business, or establishment in which employed (or employer) Farming & Live Stock
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Hugh Nugent
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Bridget
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Frank Nugent
(Address) Gifford Ida

15. Filed Jan 1, 1930 Susan E Orme Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Mar 9, 1930
that I last saw h alive on Mar 9, 1930
and that death occurred, on the date stated above, at 2.51 A m.
The CAUSE OF DEATH* was as follows:

Acute Nephritis
Pneumonia (duration) yrs. + mos. ds.
CONTRIBUTORY (Secondary) Don't know
(duration) yrs. + mos. ds.

18. Where was disease contracted if not at place of death? Gifford Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory tests
(Signed) O. E. Carnegie M. D.
3/10, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	3/11 1930

20. Undertaker Vassar Mortuary Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Burial

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70644

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 9.6
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 110

2. FULL NAME Betty Craig
(a) Residence. No. Leland Idaho St. Leland Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Oral Craig

6. DATE OF BIRTH (month, day and year) 8/20/1895

7. AGE Years 34 Months 6 Days 19 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. C.

PARENTS
10. NAME OF FATHER Marcus Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.
12. MAIDEN NAME OF MOTHER Anna Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Mrs Oral Craig
(Address)

15. Filed Jan 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 7, 1930, to Mch 9, 1930
that I last saw her alive on Mch 8 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Influenza resulting in Broncho Pneumonia
(duration) yrs. 2 wks. mos. ds.
CONTRIBUTORY (Secondary) Advanced Pulmonary Tuberculosis (duration) Several years yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kendrick Idaho
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W Johnson M. D.
Mch 10, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Leland Idaho
Date of Burial 3/11 1930

20. Undertaker Vassar Mortuary Inc Lewiston Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Carssow.

RECEIVED JUN 17 1930

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70645

Registration District No. 930

Primary Registration District No.

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Laura Billings Morris

(a) Residence. No. Thompson Apts. St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. B. Morris

6. DATE OF BIRTH (month, day and year)

7. AGE 71 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Toronto Canada.

PARENTS

10. NAME OF FATHER Theo. S. Billings

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Elizabeth Hutchison

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Ben Morris

(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 24th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5th, 1930, to Mar 24th, 1930

that I last saw her alive on Mar 24th, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chr Interstitial Nephritis

(duration) yrs. + mos. ds.

CONTRIBUTORY (Secondary) Done know

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) O C Carssow, M. D.

3/26, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho

Date of Burial 3/26 1930

20. Undertaker Brower-Wann C Lewiston Idaho

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

white

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70647

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1009
(No. 1702 G. Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Charles E. Knapp.

(a) Residence. No. 1702 G. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 5/24/1863.

7. AGE: 66. Years | Months: 10. | Days: 6. | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Building contractor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: Abel Knapp.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.
12. MAIDEN NAME OF MOTHER: Mary Wilcott.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant
(Address) Lewiston, Idaho.

15. Filed Apr. 1, 1930 D. E. T. Bruce Registrar
Per J. M. Lyle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/30-1930, 19, to 3/30-1930, 19
that I last saw him alive on 3/30-1930, 19
and that death occurred, on the date stated above, at 1 30 p. m.
The CAUSE OF DEATH* was as follows:
apoplexy
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? signs & symptoms
(Signed) H. Rouse, M. D.
3/31/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. | Date of Burial: 4/1/30. 19

20. Undertaker: Brower-Wann Company. | Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lytle

DO NOT WRITE IN THIS SPACE
State File No. 7[illegible]

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

31

2. FULL NAME Lottie Napier.

(a) Residence. No. 522 5th, Avenue. xx
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Edward Usher.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER ------- Paft.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930. Swan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 4th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10th, 1930, to April. 3rd. 1930
that I last saw her alive on Mar. 30th, 1930
and that death occurred, on the date stated above, at 5:30 P.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tbc.
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Nephritis + anem-
rism (duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. T. Mamaland, M. D.
4/5/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

White

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 96

DO NOT WRITE IN THIS SPACE
State File No. 70649

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No. 1009

Local Registrar's No.

(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Stephen D. Hughes.

(a) Residence. No. 1734 7th, Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 13th, 1861.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68.	5.	17.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chaney, Illinois.

PARENTS

10. NAME OF FATHER Joseph Hughes.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Margaretta Hughes.
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 30th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/18-1930, 19, to 3/30-1930, 19
that I last saw him alive on 3/30-1930, 19
and that death occurred, on the date stated above, at 9 15 A. m.

The CAUSE OF DEATH* was as follows:
Primary carcinoma of gall bladder, secondary carcinoma of stomach
(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) H. Rouse M.D. M. D.

3/31/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	4/1/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70650

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

66

2. FULL NAME Lizzie Smith
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 19 1904

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
25	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Wm Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Jane Henry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Wm Smith
(Address) Lapwai Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Accidental Death
Suffication - over Indulgence (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E W Brower Coroner M. D.
4/8, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jacques Spur Ida
Date of Burial: 4/8 1930

20. Undertaker: Brower - Hamilton
Address: Lewiston Idaho

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20681

PLACE OF DEATH
County of Nez Perce
City of Lewiston
near Forest.

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No. 164 ✓)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Wright Bagnall
(a) Residence. No. Forest St Forest, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 14, 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Homesteader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Mercer
(State or country) Penna

PARENTS

10. NAME OF FATHER Chas Bagnall
11. BIRTHPLACE OF FATHER (city or town) England
(State or Country)
12. MAIDEN NAME OF MOTHER Ann Ibbs.
13. BIRTHPLACE OF MOTHER (city or town) England.
(State or Country)

14. Informant C. B. Bagnall
(Address) Corvallis Ore.

15. Filed Jan 1, 1930 Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Strangulation
Hanging by neck-Suicide
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E M Brower Coroner
4/10, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	4/13 1930

20. Undertaker	Address
Brower-Ware Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70652

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Lucy Ethel Wells

(a) Residence. No. Weippe Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph R. Wells

6. DATE OF BIRTH (month, day and year): May 9 1875

7. AGE: Years 54 Months 11 Days 2 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: Richard Simmons

11. BIRTHPLACE OF FATHER (city or town) (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Cyntha Baker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): dont know

14. Informant: V. L. Wells

(Address): Craigmont Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 24th, 1930, to Apr 12th, 1930

that I last saw her alive on Apr 12th, 1930

and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. + mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of uterus

(duration) yrs. + mos. ds.

18. Where was disease contracted if not at place of death? Yrs Idaho

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Presence of tumor & section

(Signed) O C Carscont, M. D.

4/12, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weippe Idaho

Date of Burial: 19

20. Undertaker: Vassar Mortuary Inc.

Address: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7[illegible]

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 6

Primary Registration District No. 109

(No. 504 6th, Ave.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

748

2. FULL NAME Mary Augusta Porter.

(a) Residence. No. 504 6th, Ave. XXX

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 10th, 1856.

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
73.	10.	19.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER ------ Plant.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Ray R Porter

(Address) Great Falls, Montana.

15. Filed 6-1-, 1930 J M Kyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to May 29, 1930

that I last saw her alive on May 28, 1930

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ____ yrs. ____ mos. 10 ds.

CONTRIBUTORY (Secondary) Art. Hypertension

(duration) 3 yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____ Date of death

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Blaauwsalager M. D.

5/31/30., 19__ (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	5/31/30. 19
20. Undertaker	**Address**
Brower-Mann Company.	Lewiston, Idaho

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70[illegible]

PLACE OF DEATH

County of Nez Perce
City of Lewiston

Registration District No. 46
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44a

2. FULL NAME Thelma Leona Case (Parks)

(a) Residence. No. 835 - Second St. Clarkston, Wash
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Earl Case

6. DATE OF BIRTH (month, day and year): May, 19, 1907

7. AGE: 23 Years | Months | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Culdesac, Idaho

PARENTS

10. NAME OF FATHER: Edgar M. Parks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Bedford, Iowa
12. MAIDEN NAME OF MOTHER: Hattie Burks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bedford, Iowa

14. Informant: Mrs. C. H. Dyken
(Address) Clarkston, Wash.

15. Filed 6-1, 1930 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 26, 1930
that I last saw her alive on May 26, 1930
and that death occurred, on the date stated above, at 7 15 P m.
The CAUSE OF DEATH* was as follows:
Acute Endocarditis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Acute Nephritis Complicating Pregnancy
(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes Date of May 22
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [illegible], M. D.
5/27, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston Wash | Date of Burial: 5/28 1930

20. Undertaker: H P Merchant | Address: Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7[illegible]

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 9 6

Primary Registration District No. 1004

Local Registrar's No.

(No. 1312 12th, Avenue.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44 D

2. FULL NAME Grace Lind.

(a) Residence. No. 1312 12th, Avenue. Stx

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 30th, 1908.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21.	5.	24.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Public school teacher.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Barnard, Minnesota.

PARENTS

10. NAME OF FATHER A. J. Lind.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Grace Call.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota.

14. Informant A. J. Lind.

(Address) Lewiston, Idaho.

15. Filed 6-10, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 24th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to May 24, 1930,

that I last saw her alive on May 21st, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Lane Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) O. C. Corson, M. D.

5/25/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	5/27/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE

State File No. 20653

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44B

2. FULL NAME Nils Johnson.

(a) Residence. No. St. Orchards.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): December 17th, 1847.

7. AGE: Years 82. Months 5. Days 4. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden.

PARENTS

10. NAME OF FATHER: Johan Johanson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Betsy ---------.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden.

14. Informant: Mrs. Betsy Hedeen
(Address) Lewiston, Idaho.

15. Filed 6-10, 1930 J.M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 21st, 1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to May 21, 1930 that I last saw him alive on May-20, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J.M. Lyle, M. D.

5/22/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Troy, Idaho. Date of Burial: 5/25/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

Clark

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70657

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1069.

Local Registrar's No.

(No. St Joseph.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Claus Henrick August Carstens.

(a) Residence. No. St. Reubens, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) November 9th, 1861.

7. AGE Years: 68. Months: 6. Days: 11. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant F. K. Dammarell
(Address) Reubens, Idaho.

15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 20th, 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 20, 1930 that I last saw him alive on May 19, 1930 and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows: Diabetic Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic gangrene

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W O Clark, M. D.

5/21/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Reubens, Idaho. Date of Burial: 5/24/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70659

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. ~~96~~ 92
Primary Registration District No. 1009
(No. Lewiston Orchards)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Emma L. Howe
(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mark Howe
6. DATE OF BIRTH (month, day and year) Apr 6 1869
7. AGE Years 61 Months 1 Days 14 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS
10. NAME OF FATHER Will Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Mary Priestly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant H. Howe
(Address) Lewiston Idaho
15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 20, 1930
that I last saw her alive on May 18, 1930
and that death occurred, on the date stated above, at 12:50 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. O. Clark, M. D.
5/20 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 5/21 1930
20. Undertaker Vassar Mortuary Inc.
Address Lewiston

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7888

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME David Love.
(a) Residence. No. 1428 G. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23rd, 1864.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66.	-0-	26.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS
10. NAME OF FATHER William Love.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Rachael Rowe.
(Address) Lewiston, Idaho.

15. Filed 6-1, 1930 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1929, to May 19, 1930
that I last saw h[illegible] alive on May 18, 1930
and that death occurred, on the date stated above, at 6-30 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Prostatitis
(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
5-19, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	19 5/21/30.
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. 1122 — Main St.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

64

2. FULL NAME Horace C. Hearing

(a) Residence. No. 1122 Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 27 - 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	4	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) La Grande
(State or country) Oregon

PARENTS

10. NAME OF FATHER Benjaman Hearing
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Anna Hadley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Lois Hughman
(Address) Orofino, Idaho

15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 19, 1930
that I last saw h alive on May 18, 1930
and that death occurred, on the date stated above, at 4 a. m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of Heart
(due to alcoholism)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) alcoholism
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal symptoms
(Signed) E. L. White, M. D.
5/20, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
La Grande Oregon	
20. Undertaker	Address
Brown-Mann Co	Lewiston Idaho

RECEIVED JUN 17 1930

70662

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70662

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 1205 - 8th Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME W. B. Inglis

(a) Residence. No. 1205 8th Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Inglis

6. DATE OF BIRTH (month, day and year)

7. AGE Years 89 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS
10. NAME OF FATHER William Inglis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Isabelle Glendenning
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs L H Hirsch
(Address) Lewiston Idaho

15. Filed 6-17, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12:30 P. m.
The CAUSE OF DEATH* was as follows:
Cancer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Gaylord Kinnan, M. D.
5/20, 1930 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 5/20 1930

20. Undertaker Vassar Mortuary Inc.
Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70663

PLACE OF DEATH

County of Nez Perce.

City of Idaho.

Registration District No. 16

Primary Registration District No. 1009

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

184C

2. FULL NAME Earnest E. Frank.

(a) Residence. No. ..... St. Spalding, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Indian.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 27th, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
----	1.	21.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spalding, Idaho.

PARENTS

10. NAME OF FATHER Jones Frank.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Louise Blackhawk.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Louise Blackhawk Frank

(Address) Spalding, Idaho.

15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The ~~CAUSE~~ OF DEATH* was as follows: Fracture Skull

Auto accident.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Emil Brown Coroner, M. D.

5/20/30., 19..... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spalding, Idaho.	5/20/30. 19
20. Undertaker	**Address**
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1827 7th, Avenue.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME James S. McKissick.

(a) Residence. No. 1827 7th, Avenue. ~~XX~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 20th, 1878.

7. AGE: Years 52. Months --- Days 28. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Mill worker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clearwater Timber Company.

9. BIRTHPLACE (city or town) (State or country): Columbia, Tenn.

PARENTS

10. NAME OF FATHER: James McKissick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Martha Manier.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn.

14. Informant: [illegible]

(Address) Lewiston, Idaho.

15. Filed May 26 1930 T34 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17th, 1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 17, 1930 that I last saw him alive on May 17, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E. G. Broddock, M. D.

5/18/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 5/19/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70660

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

70

2. FULL NAME Elva Agnes Pelton

(a) Residence. No. St. Salmon City Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 5th 1910

7. AGE Years: 20 Months: 2 Days: 5 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Normal Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS
10. NAME OF FATHER: Jas. L. Pelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Dora M. Lodders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utaha.

14. Informant: Mrs J. L. Pelton
(Address) Salmon City. Idaho

15. Filed 5-20, 1930 S. E. Bruce Per J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 15th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 15, 1930
that I last saw her alive on May 15, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Acute Hemorrhagic Encephalitis
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? n
What test confirmed diagnosis? Exam Spinal Fluid
(Signed) E. G. Brassock, M. D.
5/16, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City Utah
Date of Burial 19

20. Undertaker: Brower - Wann & Lewiston Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70666

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

111 B

2. FULL NAME John Kinger
(a) Residence. No. Uniontown Wn St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Kinger
6. DATE OF BIRTH (month, day and year) Sept 10
7. AGE Years 47 Months 6 Days 7 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) General farming
(c) Name of employer self
9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS
10. NAME OF FATHER Jacob Kinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Spenenvaber
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Louise Kinger
(Address) Uniontown

15. Filed 5-20, 1930 S. E. Bruce Registrar
Per Joseph Lyle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1930 (Year)
~~May 10~~

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 17, 1930
that I last saw him alive on May 17, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? uncertain wash
Did an operation precede death? yes Date of May 6 1930
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) E. G. Broadbent, M. D.
May 17, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Uniontown Wn
Date of Burial 19
20. Undertaker Vassar Mortuary Lewiston
Address

RECEIVED JUN 17 1930

PLACE OF DEATH

County of Nez Perce

City of Lewiston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. Whites Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70607

Local Registrar's No.

131

2. FULL NAME Florence Craig

(a) Residence. No. 418 Miller St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15 - 1901

7. AGE Years 28 Months 10 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clinton Minnesota

PARENTS

10. NAME OF FATHER Albert Regge

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Josephine Westling

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Josephine Reiber

(Address) Lewiston, Idaho

15. Filed May 20, 1930 Susan Bruce Registrar
By Jm. Lyle

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 12, 1930

that I last saw her alive on May 12, 1930

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia Post operative (anuria.)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Post operative adhesions and chololithiasis

(duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 9th 30

Was there an autopsy? No

What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.

5/13, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho

Date of Burial: 5/15 1930

20. Undertaker: Brower-Dunn Co. Lewiston Idaho

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Carson

DO NOT WRITE IN THIS SPACE

State File No. 70063

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

128

2. FULL NAME Amy Viola Moats

(a) Residence. No. 1707 Carson Ave ~~St.~~ (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16 - 1872

7. AGE: Years 57 Months 10 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: Lindsey Hendricks

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah Edwards

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: E. Moats

(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3rd, 1930, to May 10th, 1930

that I last saw her alive on May 10th, 1930

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Elephantiasis

(duration) 24 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Physical

(Signed) O. C. Carson, M. D.

5/11, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston Wash

Date of Burial: 5/11 1930

20. Undertaker: Brower - Wann E Lewiston Idaho

Address

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20683

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Robert Purdy

(a) Residence. No. ..... St. Orogrande Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12/6/1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Burton
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1930, to May 6, 1930
that I last saw him alive on May 6, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Microscope
(Signed) J. M. Boyle, M. D.
5/8/1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	5/9/1930

20. Undertaker Brower-Wenn Co Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Stockbridge

DO NOT WRITE IN THIS SPACE

State File No. 70678

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Martin V. Thomas

(a) Residence. No. St. Kendrick Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/12/1854

7. AGE 76 Years 3 Months 24 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Banker

(b) General nature of industry, business, or establishment in which employed (or employer) and Farmer.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10. NAME OF FATHER Nathan Thomas

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W. W. Thomas
(Address) Lewiston, Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1930, to May 6, 1930

that I last saw him alive on May 6, 1930

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Art. Hypertension

Nephritis (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L B Storadagre, M. D.

5/7, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cimeriam Ridge Cemetery

Date of Burial 5/8 1930

20. Undertaker Brower-Wann & Lewiston Idaho

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Human

DO NOT WRITE IN THIS SPACE
State File No. 70672

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 442 — Miller St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME Eli Asbury Leach

(a) Residence. No. 442 — Miller St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 15 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74	8	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Belathell Leach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Mary Varner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs Warren Banks
(Address) Craigmont, Idaho

15. Filed Jan 1, 1930. Susan E Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 5, 1930, that I last saw him alive on May 5, 1930, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Heart failure
from Cerebral stroke
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Lafayette Swanson M. D.
5-6, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Craigmont Idaho	5/7 1930

20. Undertaker Address
Brower-Ware Co. Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70673

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

88 (B)

2. FULL NAME H. Gossard
(a) Residence. No. Grand Hotel Lewiston St. Winchester Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dont Know

7. AGE Years 62 Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Camp Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Co.
(c) Name of employer Craig Mountain Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Records Whites Hospital
(Address) By Oliver R Vassar - Lewiston Ida

15. Filed Jan 1, 1930. Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to May 2nd, 1930
that I last saw him alive on May 2, 1930
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
myocarditis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chr. Endocarditis with arteriosclerosis.
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
5/31, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 5/4 1930

20. Undertaker Vassar Mortuary Inc.
Address Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 13 1930

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. 1302 Main Street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 7[illegible]

Local Registrar's No.

90

2. FULL NAME Emma F. Jones.

(a) Residence. No. 1302 Main St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of A. Jones.

6. DATE OF BIRTH (month, day and year) March 11th, 1875.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55.	1.	21.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER James McMullan.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Nancy Stepp.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant A. Jones.

(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 1st, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to May 3, 1930

that I last saw her alive on May 1st, 1930

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Valvular insufficiency

(duration) 5 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) Ends carditis

(duration) 9 yrs. 0 mos. 9 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symp

(Signed) E. E. Watts, M. D.

5/2/30., 19__ (Address) Gifford, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	5/5/30. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

RECEIVED JUN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70675

PLACE OF DEATH
County of Oneida
City of Malad.

Registration District No. 26
Primary Registration District No. 2064
(No.) Local Registrar's No. 23

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Ella Elena Sanford Dillon

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced ~~HUSBAND or~~ (or) WIFE of Christopher Columbus Dillon

6. DATE OF BIRTH (month, day and year) Dec. 12-1858

7. AGE Years 71 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Woodstock Ill.

PARENTS
10. NAME OF FATHER Charles Sanford.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Betsy Joslin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont.

14. Informant R. M. Dillon
(Address) Sinclair, Idaho

15. Filed 5/31, 1930 J. M. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May. 19. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to May 19, 1930
that I last saw her alive on May 19, 1930
and that death occurred, on the date stated above, at 8.10 A. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Spokane Wash.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) V. P. Gant M. D.
May 20, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash
Date of Burial: May 24, 1930

20. Undertaker: J. Guy Benson
Address: Malad Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 2077

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 20
Primary Registration District No. 2069
Local Registrar's No. 72

(No.) 170
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Llewellyn Thomas

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24. 1879

7. AGE	Years	Months	Days	If LESS than 1 day,
	50	10	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho

PARENTS

10. NAME OF FATHER Henry Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Sarah Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mrs J. F. Morgan
(Address) Salt Lake City.

15. Filed 6/31, 1930 J. M. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Coroners Jury Verdict:
"Died by His own hand"
(Suicide through throat

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Jos R Davis (Coroner) M.D.
, 19 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	May 16 1930

20. Undertaker	Address
J. Guy Keenan	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70677

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

131

2. FULL NAME John William Davis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lucy Jones

6. DATE OF BIRTH (month, day and year) Feb. 19-1847

7. AGE Years 83 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining - Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pyle Wales

PARENTS

10. NAME OF FATHER Evan Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Ann Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Lewis Davis
(Address) Malad Ida

15. Filed 5/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) - 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to , 1930
that I last saw him alive on April , 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Anemia from nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) V. P. Gant, M. D.
May 13, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial May 14 1930

20. Undertaker J. Guy Henson
Address Malad Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20678

RECEIVED JUN 11 1930

PLACE OF DEATH
County of Owyhee
City of Homedale Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 65
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Perry Moore

(a) Residence. No. Homedale St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs. Melvina Evon Moore

6. DATE OF BIRTH (month, day and year) Mar 13-1859.

7. AGE: Years 71 | Months 2 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indianna

PARENTS

10. NAME OF FATHER Ennis Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Lydia Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant (Address) Herschel Moore Homedale, Ida.

15. Filed 6-4-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to May 31, 1930, that I last saw h.. alive on May 31, 1930 and that death occurred, on the date stated above, at 6 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremic Poisoning which caused heart trouble.
(duration) 3 yrs. 5 mos. — ds.
CONTRIBUTORY (Secondary) Arteriosclerosis from Colon (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes Statements of family
What test confirmed diagnosis?
(Signed) W. H. L. Broadhurst M. D.
6/3, 1930 (Address) Caldwell, Ida.

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 6-4 1930
20. Undertaker: Paul L. Case | Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70679

PLACE OF DEATH
County of Payette
City of New Plymouth

Registration District No. 5
Primary Registration District No. 2009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

A8 e

2. FULL NAME Chas L Martin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Leona M Martin

6. DATE OF BIRTH (month, day and year) Apr 24 1867

7. AGE Years 62 Months 11 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓ ✓

14. Informant B. F. Talbot
(Address) New Plymouth Ida

15. Filed Apr 23, 1930 Wm I Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Car Accident crushed skull and Burning
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. H. Cedar Cooper M. D.
4/23, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal New Plymouth — Date of Burial Apr 23

20. Undertaker J. H. Cedar Peterson Turn Co — Address Payette Ida

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 26 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 5

County of Payette

Primary Registration District No. 1009

File No. 70680

City of

(No. , St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Schisler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. ✓ (Write the word.)

6. DATE OF BIRTH. Apr (Month) 14 (Day) 1930 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Schisler

11. BIRTHPLACE OF FATHER (State or Country) Ark

12. MAIDEN NAME OF MOTHER Amy Ferguson

13. BIRTHPLACE OF MOTHER (State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm T Drysdale

(Address) New Plymouth

15. Filed 4-16 1930 Wm T Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH Apr (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from from birth 191 , to Apr 16 1930, that I last saw him alive on " 191 ", and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Insufficient Foetal development
6-7 mo gestation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Wm T Drysdale M. D.

4-16 1930 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth

DATE OF BURIAL: 4-16 1930

20. UNDERTAKER: None

ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70681

PLACE OF DEATH
County of Payette
City of Fruitland Beach

Registration District No. 51
Primary Registration District No. 2130
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Rosa A Horn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day and year) Oct 20 1924

7. AGE Years 5 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Roy E Horn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Maude Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebr

14. Informant Nettie M Horn
(Address) Payette Ida

15. Filed Apr 10, 1930. Mrs Wm T. Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 28, 1930, to Apr 7, 1930
that I last saw her alive on Apr 7, 1930
and that death occurred, on the date stated above, at 12 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia -

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? clinical evidence
(Signed) Wm T Drysdale, M. D.
4-10, 1930 (Address) Mrs Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Ida — Date of Burial Apr 9 1930

20. Undertaker G H Adair — Address Peterson Furn Co Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 17

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mary Wasson

(a) Residence. No. 330 - 3rd ave. North St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Wasson

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: 62 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Wm Klopfenstein
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Elizabeth Klopfenstein
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Frank Wasson
(Address) Payette Ida

15. Filed May 26, 1930 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 23, 1930
that I last saw h-- alive on May 23, 1930
and that death occurred, on the date stated above, at 7 30 a. m.
The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J C Woodward, M. D.
6/1, 1930 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette - Ida.	May 26 1930
20. Undertaker	Address
Glenn C Landon -	Payette Ida.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70683

PLACE OF DEATH

County of Payette
City of Fruitland Ida

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 16

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Theresa Tabert.
(a) Residence. No. Fruitland Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Tabert.

6. DATE OF BIRTH (month, day and year): Oct 20.

7. AGE: Years 75 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10. NAME OF FATHER: Minnch.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Russia.
12. MAIDEN NAME OF MOTHER: unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown.

14. Informant .....
(Address) Guss Dan

15. Filed May 7, 1930 Boise Ida J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 5, 1930
that I last saw her alive on May 5, 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis with heart block (Stokes Adams syndrome) indefinite (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. [illegible], M. D.
May 6, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise. Ida. | Date of Burial: May 8 1930

20. Undertaker: Glenn C Landon | Address: Payette. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20684

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 15

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

154C

2. FULL NAME Dorothy Moulton

(a) Residence. No. 122 W. Seattle St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): baby
5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of:
6. DATE OF BIRTH (month, day and year):
7. AGE — Years | Months | Days | If LESS than 1 day, 4 hrs. or ~~min.~~
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: E. Russel Moulton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: Dorothy Sur
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: E. Russel Moulton
(Address): Payette Idaho

15. Filed May 5, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 4, 1930
that I last saw her alive on May 4, 1930
and that death occurred, on the date stated above, at 4 17 a m.
The CAUSE OF DEATH* was as follows:
Atelectasis
(duration) yrs. mos. 4 hr ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) O. H. Avey, M. D.
May 7, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette Ida — Date of Burial: May 6 1930
20. Undertaker: Glenn C Landon — Address: Payette Ida

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20685

PLACE OF DEATH

County of .....

City of .....

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 14

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida E Van Ethen 57

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, or Divorced (write the word)

5a. If ~~married, widowed~~, or divorced ~~HUSBAND of~~ (or) WIFE of D B Van Ethen

6. DATE OF BIRTH (month, day and year) Aug 4 1872

7. AGE Years 58 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Leo Babcock

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Mary Eason

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant S B Van Ethen
(Address) Payette Ida

15. Filed May 3, 1930 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25, 1930, to May 2, 1930

that I last saw her alive on May 2, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Diabetes

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetic gangrene

..... (duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J R Woodward, M. D.

May 4, 1930 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Ida — Date of Burial May 4 1930

20. Undertaker J H Adam — Address Peterson Fur Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 13

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Mrs Jemima Jones.

(a) Residence. No. 135 North 10th St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. Abner Jones.

6. DATE OF BIRTH (month, day and year): Feb 22.

7. AGE: Years 83 | Months 2 | Days 7. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired house wife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): virginia

PARENTS

10. NAME OF FATHER: Mark Poole.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown.

12. MAIDEN NAME OF MOTHER: Susan Pool.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Eng.

14. Informant: Mrs Maggie Phipps

(Address): Payette. Idaho.

15. Filed: Apr 30, 1930 J. C. Woodward, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27, 1930, to Apr 28, 1930

that I last saw her alive on Apr 28, 1930

and that death occurred, on the date stated above, at 12.05 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis – chronic

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) O H Avey, M. D.

Apr 30, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette. Ida.

Date of Burial: April 30 1930

20. Undertaker: Glenn C. Sandon.

Address: Payette. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1930

PLACE OF DEATH

County of Payette.

City of Payette

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 4

Primary Registration District No. 1008.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

Local Registrar's No. 12.

2. FULL NAME Phoebe Roma Genoway

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): widowed.

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cyrus L. Genoway.

6. DATE OF BIRTH (month, day and year): June 23 1860

7. AGE — Years: 69 | Months: 9 | Days: 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home wife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10. NAME OF FATHER: Mr. Shottenfirth.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Mary Genoway
(Address) Payette, Ida.

15. Filed Apl 9, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19, 1930, to Apr. 8, 1930, that I last saw h[illegible] alive on Apr. 8, 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* ~~was as follows~~:

Carcinoma, transverse colon with generalized metastases.

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mar. 24, 1930

Was there an autopsy? no.

What test confirmed diagnosis? Microscopy

(Signed) Merle R. Fox M. D.

Apr. 9, 1930 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Ida.	April 11 1930
20. Undertaker	Address
Glenn C Landon	Payette - Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 11

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mary Jane Clement

(a) Residence. No. 117 N. Ninth St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob E. Clement

6. DATE OF BIRTH (month, day and year) March 23 1838

7. AGE Years 92 Months — Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Linus Hayse

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Clarissa Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant L. T. Clement (Address)

15. Filed Apr 7, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1920, 19, to April 6, 1930

that I last saw her alive on April 6, 1930

and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Infirmaties of Age

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) O. H. Avey, M. D.

Apr 7, 1930 (Address) Payette Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Ida — Date of Burial April 8 1930

20. Undertaker Glenn C Sanders — Address Payette Ida

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70689

PLACE OF DEATH

County of Boyette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10.

164

2. FULL NAME Josef Valasek

(a) Residence. No. (Usual place of abode) near Nampa Ida.
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	4	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10. NAME OF FATHER Valasek

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bohemia

14. Informant J. H. Cidar
(Address) Payette

15. Filed Mar 27 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 25 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Suicide by hanging on the Snake River Bridge between Ontario & Payette (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. H. Cidar Coroner M. D.
Mar 27, 1930 (Address) Payette

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette	Mar 29 1930
20. Undertaker J. H. Cidar Peterson Furn Co	Address Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70690

PLACE OF DEATH
County of Fayette
City of Fayette

Registration District No. 4
Primary Registration District No. 1008
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

91a

2. FULL NAME Albert M McKibbin

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Leola McKibbin

6. DATE OF BIRTH (month, day and year) Mar 19 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	—	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida Ho

PARENTS
10. NAME OF FATHER Alec McKibbin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Leeper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Leola McKibbin
(Address) Fayette Ida

15. Filed Mar 26 1930 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1930, to Mar 25 1930
that I last saw h~~im~~ alive on Mar 25 1930
and that death occurred, on the date stated above, at 2:30 p. m.
The CAUSE OF DEATH* was as follows:
Aneurism of Thoracic aorta
b
Intermittent (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Syphilis
Intermittent (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Wassermann - X-Ray

(Signed) J R Woodward, M. D.
3/26, 1930 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain Home Ida	Mar 27 1930
20. Undertaker	Address
Holidays Peterson Funeral Home	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70691

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
(No.) Local Registrar's No. 8

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mary T. Wild
(a) Residence. No. 2nd Ave. S 12 St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam J. Wild

6. DATE OF BIRTH (month, day and year): Mar 3, 1855

7. AGE: Years 75, Months —, Days 22. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kittanning Penn

PARENTS
10. NAME OF FATHER: Steine
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Scott Brubaker
(Address) Payette Idaho

15. Filed Mar 25, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Mar. 25, 1930
that I last saw her alive on Mar. 25, 1930
and that death occurred, on the date stated above, at 7 45 P. m.
The CAUSE OF DEATH* was as follows:
Cardio-vascular - renal disease
indefinite (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Lot, M. D.
Mar. 25, 1930 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Ida. Date of Burial: Mar 27 1930

20. Undertaker: Glenn C. Landon. Address: Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. .....

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs Mary T. Wild.

(a) Residence. No. 3rd ave B. 12 th St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	White	widow

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75		22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Kittanning
(State or country) Penn.

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) unknown.

14. Informant .....
(Address)

15. Filed ....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cardio-vascular renal disease

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....
(Signed) Merrill R. Fay, M. D.
....., 19..... (Address).....

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	Mar 27 1930
20. Undertaker	Address
Glenn C Sanders	Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70692

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7.

47

2. FULL NAME Amanda Dougherty

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of E S Dougherty

6. DATE OF BIRTH (month, day and year) Oct 4 1881

7. AGE Years 48 Months 5 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS
10. NAME OF FATHER Amos Coulter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ ✓
12. MAIDEN NAME OF MOTHER Hulda Grimm
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant Leo. E. Dougherty
(Address) Payette, Ida.

15. Filed Mar. 17, 1930 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2, 1930, to ....., 19..
that I last saw her alive on Mar 2, 1930
and that death occurred, on the date stated above, at 12.30 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of breast

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? No test
(Signed) O. H. Avey, M. D.
Mar 18, 1930 (Address) Payette, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside Cem Payette
Date of Burial: Mar 16 1930

20. Undertaker: Peterson Furn Co
Address: Payette Ida

RECEIVED JUN 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20693

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME James M. Wheeler
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years — Months — Days ✓ If LESS than 1 day, 2½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER F. G. Wheeler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Josephine Van Dun
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Net

14. Informant J. G. Wheeler
(Address) Fruitland Ida

15. Filed Mar 15, 1930. J. G. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 3, 1930
that I last saw him alive on Mar 3, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Premature birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? Clinical
(Signed) W. J. Weese M. D.
2/8, 1930 (Address) Ontario Ore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Payette Riverside — Date of Burial Mar 4 1930

20. Undertaker I. H. Gdain Peterson Furn Co — Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70694

PLACE OF DEATH
County of Power
City of American Falls

Registration District No. 25
Primary Registration District No. 2072
(No. Bethany)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

24

2. FULL NAME Alvin E. Baer
(a) Residence. No. Aberdeen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Oct. 3, 1916

7. AGE Years 13 Months 8 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aberdeen, Idaho

PARENTS
10. NAME OF FATHER Edward B. Baer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Katherine Friesin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant E. B. Baer
(Address) Aberdeen, Idaho

15. Filed May 28, 1930 Genevieve Nolte Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 27, 1930
that I last saw him alive on May 27, 1930
and that death occurred, on the date stated above, at 7:45 a.m.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis
Epidemic Type
(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) [illegible], M. D.
5/27, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Aberdeen Ida
Date of Burial May 28 1930

20. Undertaker Al Davis
Address ~~Aberdeen~~ American Falls Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH

County of Power
City of Neeley

CERTIFICATE OF DEATH

Registration District No. 25
Primary Registration District No. 2072 Local Registrar's No. 9
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Hattie L Jones

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amos Jones

6. DATE OF BIRTH (month, day and year) Sept. 27 1861

7. AGE Years 68 Months 7 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan Ut.

PARENTS

10. NAME OF FATHER David B Dille
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Minerva Stowell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York

14. Informant (Address) Myrtle Sheppard American Falls Ida

15. Filed May 8, 1930 Gwinnie Nott Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 8, 1930
that I last saw ~~her~~ alive on May 8, 1930
and that death occurred, on the date stated above, at 4:50 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) P G Logan, M. D.
May 8, 1930 (Address) [illegible]

19. Place of Burial, Cremation, or Removal Neeley Ida. Date of Burial May 10 1930

20. Undertaker D. E. Johnson Address Burley Idaho

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED MAY 24 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 10696

Registered No. 46

1. PLACE OF DEATH.

Registration District No. 20

Primary Registration District No. 10 11

County of Shoshone

City of Wallace Ida. (No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William S Brown.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 10 (Month) 12 (Day) 1858 (Year)

7. AGE 71 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: W Brown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G M Rigney

(Address) Shoshone County Idaho

15. Filed May 3 1930 J L Quigley Local Registrar

BYNS - YORK CO., PTRS. & ENGRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 30 (Day) 1930 (Year) 49

17. I HEREBY CERTIFY, That I attended deceased from 8-12-1929, to 4-30 1930, that I last saw him alive on 4-30-1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma Axilla left

(Duration) Yrs. 8 mos. ds.

Contributory (Secondary) Carcinoma hand (left)

(Duration) Yrs. mos. ds.

(Signed) James R Brown M. D.

19 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 8 mos. 18 days. In the State 45 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Wallace Ida.

Former or usual residence Wallace Ida Same

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho — DATE OF BURIAL May 3 1930

20. UNDERTAKER J A Bewer Ward Undr Co — ADDRESS Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 50697

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

88 (0

2. FULL NAME Mary Henry
(a) Residence. No. 418 Cedar St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Jan - 22 - 1860

7. AGE Years 70 Months 1 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Freeport Ill.

PARENTS
10. NAME OF FATHER John Gearon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Bridget Hines
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs John Moffitt
(Address) Wallace Idaho

15. Filed 4-27, 1930 E. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 26 1930
that I last saw her alive on April 26, 1930
and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis
Chr Parenchymatous Nephritis
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys Exam. Lab tests
(Signed) Max F. Smith, M. D.
4/26/30, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash. Date of Burial Shipped Apr 27 30

20. Undertaker J. A. Bever Ward Und Co. Address Wallace Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

119

2. FULL NAME Matt Wuolle
(a) Residence. No. Cataldo, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. ~~If~~ married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of: Maria Matilda Wuolle

6. DATE OF BIRTH (month, day and year): Mch. 13 1883

7. AGE: 47 Years | Months: 1 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Finland

PARENTS
10. NAME OF FATHER: Samuel Wuolle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Finland
12. MAIDEN NAME OF MOTHER: Maki
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Finland

14. Informant: Ed Alho
(Address): Kellogg Idaho

15. Filed 4-25, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20th, 1930, to Apr 23rd, 1930, that I last saw him alive on Apr 22, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Carcinoma following Acute Appendicitis
..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes. Date of Apr 21st.
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings
(Signed) W. C. Lindsay M. D.
4/23, 1930, (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kingston, Idaho | Date of Burial: 4-25 1930

20. Undertaker: M. C. Thornhill | Address: Kellogg, Ida.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

101a

2. FULL NAME Melvin F. Ryals

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov 2nd 1874

7. AGE Years 55 Months 5 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER W. F. Ryals
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Mary Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant Mrs. Leora B. Shiffer
(Address) Middleton Idaho

15. Filed 4-29, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8, 1930, to Apr 23, 1930
that I last saw him alive on Apr 22, 1930
and that death occurred, on the date stated above, at 3:30 A.m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
Rt lung
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of Apr 8
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowery M. D.
4-23, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Colville, Idaho. Date of Burial Apr 29 1930

20. Undertaker J. A. Bower Ward Und Co Address Wallace, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 2076

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 42
(No.) 31
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Spriggs
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 18th day Oct 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Halifax Nova Scotia

PARENTS

10. NAME OF FATHER Springgs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia
12. MAIDEN NAME OF MOTHER ming.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nova Scotia

14. Informant Harold Easter
(Address) Kellogg Ida.

15. Filed 4-23, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18th, 1930, to Apr 21, 1930, that I last saw h alive on Apr 21st, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) W. Ludwig, M. D.
4/23, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg. Ida	Apr 23 1930
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED MAY 24 1930

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70701

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 41

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

118 B

2. FULL NAME Mary Hutchinson

(a) Residence. No. Mullan, Rood. St. Mullan Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 62 Years | Months 1 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Wm Tarn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Heward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mary Myklebust.

(Address) Mullan, Ida.

15. Filed 4-23, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to Apr 19, 1930

that I last saw her alive on April 19, 1930

and that death occurred, on the date stated above, at 1:15 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Immense irreducible umbilical Hernia (duration) 18 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James R Bean, M. D.

4/21/30 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho | Date of Burial Apr 23 1930

20. Undertaker J. A. Bever Ward Rud Co. | Address Wallace, Id

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE.
State File No. 20783

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

126

2. FULL NAME Mary Smiley
(a) Residence. No. Burke Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ wife of Chester H. Smiley

6. DATE OF BIRTH (month, day and year) Oct 14 1910.

7. AGE: Years 19 | Months 6 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Porter Oklahoma

PARENTS
10. NAME OF FATHER: George Oscar Banks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Chester H. Smiley
(Address) Burke Id

15. Filed Apr 22, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 17, 1930, to Apr 20, 1930
that I last saw him alive on Apr 20, 1930
and that death occurred on the date stated above, at 6 20 a m.
The CAUSE OF DEATH* was as follows:
Peritonitis General
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Ruptured Uterus
Birth Labor (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Was
What test confirmed diagnosis? None
(Signed) Dr. Mowery M.D.
4/21, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Joplin, Mo. | Date of Burial: April 22 1930.

20. Undertaker: Bruce G. Worstell | Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 10 11
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

2. FULL NAME Mitchell Winn Mariner

(a) Residence. No. Page, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6. DATE OF BIRTH (month, day and year): Nov. 17th 1905

7. AGE — Years: 24 | Months: 5 | Days: 0 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Osier Michigan

PARENTS

10. NAME OF FATHER: Jonas Mariner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Goshen Indiana
12. MAIDEN NAME OF MOTHER: Nora Chatterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin

14. Informant: Earl Mariner
(Address): Mullan Ida

15. Filed: April 1, 1930 — F. L. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 17th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18th, 1930, to April 17, 1930
that I last saw him alive on April 17th, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of 4-16-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm F. Smith, M. D.
4/17/30, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho.	April 21 1930.
20. Undertaker	Address
Drew G. Worstell	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1967

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1071
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

101a

2. FULL NAME Thomas Joseph Moonan

(a) Residence. No. Wallace Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Aletha Moonan

6. DATE OF BIRTH (month, day and year): Aug-11-1883

7. AGE: Years 46 | Months 6 | Days 6 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Barber.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Barber Shop.

9. BIRTHPLACE (city or town) (State or country): Minn

PARENTS

10. NAME OF FATHER: Andy Moonan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Bridget O Toole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada.

14. Informant: Mrs Aletha Moonan
(Address): Wallace Idaho

15. Filed Apr 21, 1930. F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows: Pneumonia Lobar
Coronary Thrombosis
(duration) ____ yrs. ____ mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Dr. H. McKay, M. D.
April 19, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	Apr 21, 1930
20. Undertaker: Ward Funeral Home	Address: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20226

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 36

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Aro

101 a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	4	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logging
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emerald

PARENTS

10. NAME OF FATHER Matt Aro
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Sophia Tenhonen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Simeon Aro
(Address) Kellogg, Idaho

15. Filed Apr 12, 1930. J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930 to Apr 11, 1930
that I last saw him alive on Apr 11, 1930
and that death occurred, on the date stated above, at 4:20 P.M.
The CAUSE OF DEATH* was as follows: Pneumococcus Lobular broncho pneumonia
Influenza
(duration) yrs. 10 days
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. few ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Ross McWard, M. D.
4/12, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kingston, Ida	Apr 13, 1930
20. Undertaker	Address
M. C. Thornburg	Kellogg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70797

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

129

2. FULL NAME Myrtle Elma Hodgen
(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13, 1916

7. AGE Years 13 Months 8 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Spokane
(State or country) Wash

PARENTS
10. NAME OF FATHER Jacob Hodgen
11. BIRTHPLACE OF FATHER (city or town) Washington
(State or Country)
12. MAIDEN NAME OF MOTHER Elma Rogers
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant Elma Hodgen
(Address) Kellogg Idaho

15. Filed Apr 8, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH Mowery

16. DATE OF DEATH Apr (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930 to Apr 6, 1930
that I last saw her alive on Apr 5, 1930
and that death occurred, on the date stated above, at 12:10 am.
The CAUSE OF DEATH* was as follows:
Nephritis Chr
Parenchymatous
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Scarlet Fever
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr. Mowery M.D.
4/7, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida
Date of Burial Apr 8, 1930

20. Undertaker M. C. Thornhill
Address Kellogg Ida

RECEIVED MAY 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20208

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 34

(No. [illegible] If death occurred in a hospital or institution, give its name instead of street and number.)

146

2. FULL NAME Gus A Larson

(a) Residence. No. [illegible] Mullan, Idaho St. Mullan
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	64			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gold Hunter Mng Co.

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant C. K Cartwright
(Address) Mullan Idaho.

15. Filed Apr 9, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h____ alive on ____, 19__
and that death occurred, on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
Chronic Nephritis
Duration 2 years
Contributory Uremia
Duration [illegible] yrs. [illegible] mos. [illegible] ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H C Howard Coroner, M. D.
4/5, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan Idaho	April 8 1930
20. Undertaker J. A. Beer	Address
Ward Und Co.	Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70709

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

44 B

2. FULL NAME Barbara Marion Hollingsworth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 26-1924

7. AGE Years 6 Months 2 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Spokane Wash
(State or country)

PARENTS
10. NAME OF FATHER Martin Ray Hollingsworth
11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)
12. MAIDEN NAME OF MOTHER Olive Merriman
13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Martin Ray Hollingsworth
(Address) Kellogg Ida

15. Filed May 31, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 11 a.m.
The CAUSE OF DEATH was as follows:
Myo Carditis, Chr
(duration) yrs. mos. ds.
CONTRIBUTORY (secondary) Severe Whooping Cough
Pneumonia (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Mowery Coroner
5/31, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida
Date of Burial June 1 1930

20. Undertaker R. L. Stout
Address Kellogg Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70711

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

2. FULL NAME Donald Garnett Griffiths 9

(a) Residence. No. Wardner St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec 28/29

7. AGE: Years 2 Months 4 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wardner Ida

PARENTS

10. NAME OF FATHER: Garnett O. Griffiths
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wardner Ida
12. MAIDEN NAME OF MOTHER: Della Sivara
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Garnet Oliver Griffiths
(Address) Wardner, Idaho.

15. Filed May 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 25, 1930
that I last saw him alive on May 25, 1930
and that death occurred, on the date stated above, at 6.30 A. m.
The CAUSE OF DEATH* was as follows:

Hooping Cough and Bowel trouble

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Mason M. D.
May 27, 1930 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: [illegible] Date of Burial: May 27 1930

20. Undertaker: McCharthee Address: Kellogg

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70711

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

90

2. FULL NAME Edward V. Swift

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie M Swift

6. DATE OF BIRTH (month, day and year)

7. AGE 54 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Mr. Swift
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No information
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) no information

14. Informant Minnie M. Swift
(Address) Ridgeth Hotel

15. Filed May 30 1930 Mrs. Helen McBride Spokane, Wash. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1925, to May 20, 1930
that I last saw him alive on May 20, 1930
and that death occurred, on the date stated above, about 830 a. m.
The CAUSE OF DEATH* was as follows: Heart failure only cause can be given without autopsy. Had eaten breakfast and was found sitting in chair with glasses on Had been reading paper. Had laid paper on the bed beside him.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Been inmate of Wardner Hospital over 6 mo.
Diderosis (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? X Ray
(Signed) Geo H. Kennett, M. D.
May 20, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg, Idaho | Date of Burial May 22, 1930

20. Undertaker M. C. Thornhill | Address Kellogg, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7071

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 27

(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Christian Miller

(a) Residence. No. 123 S. Division St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 9 mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lola May Miller

6. DATE OF BIRTH (month, day and year) Jan 3 - 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
48	1882	Jan	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Mining
(c) Name of employer Bunker Hill

9. BIRTHPLACE (city or town) (State or country) Dahlen Stettlen op Bern Switzerland

PARENTS

10. NAME OF FATHER Fred Christian Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Harold Victor Olmstead
(Address) Tekoa Washington

15. Filed May 20, 1930 Miss Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-13, 1930, to 5-17-, 1930
that I last saw him alive on 5-17-, 1930
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia · lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 12 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical.

(Signed) W. Caraway. M. D.
5-19-, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	May 19 1930
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

County of Shoshone Primary Registration District No. 2201

City of Wallace (No. ....., ... St.)

File No. 70714

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olaf Wentzel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 4 (Month) 8 (Day) 1866 (Year)

7. AGE 64 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Olaf Wentzel

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Hilda Wentzel

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. M. Rogers

(Address) Shoshone County

15.

Filed May 30 1930 Mrs. Helen M. Brice Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH 5 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-5-1929, to 5-17-1930, that I last saw him alive on 5-17-1930 and that death occured on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) James R. Bean M. D.

5/19 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 11 mos. 12 days. In the State 34 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? unknown

Former or usual residence Kellogg Ida

19. PLACE OF BURIAL OR REMOVAL Greenwood

DATE OF BURIAL May 20 1930

20. UNDERTAKER M. C. Thornhill

ADDRESS Kellogg

SYMS - YORK CO., PTRS. & BDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7073

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

204

2. FULL NAME Baby Gordon

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg, Ida
(State or country)

PARENTS

10. NAME OF FATHER Calvin Gordon
11. BIRTHPLACE OF FATHER (city or town) Nebraska
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret Hoffland
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) S. Dakota

14. Informant Calvin Gordon
(Address) Kellogg, Idaho.

15. Filed May 30, 1930 Mrs. Helen M. Brede
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14th, 1930, to , 19
that I last saw him alive on May 14th, 1930,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Prematurity ?

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. L. Lindsay, M. D.
5/15, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	May 15, 1930
20. Undertaker	Address
M. W. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70713

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

162

2. FULL NAME Baby Highbee

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS
10. NAME OF FATHER J. A. Highbee Jr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Coeur d'Alene Ida
12. MAIDEN NAME OF MOTHER Mary Rosenbaum
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant J A Higbee Jr
(Address) Cataldo Idaho

15. Filed May 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH Laraway

16. DATE OF DEATH May (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 10, 1930
that I last saw her alive on May 10, 1930.
and that death occurred, on the date stated above, at 6:50 p.m.
The CAUSE OF DEATH* was as follows:
Respiratory and Cardiac failure.
(due to cerebral pressure)
..... (duration) ..... yrs. ..... mos. 20 hours
CONTRIBUTORY (Secondary) Cerebral pressure
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) T W Laraway, M. D.
5-12-, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kingston, Idaho — Date of Burial May 12 1930

20. Undertaker M. C. Thornhill — Address Kellogg, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70717

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 23
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Monte Robert Lafferty
(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 25, 1929
7. AGE Years Months 4 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Kellogg Ida.

PARENTS
10. NAME OF FATHER Ralph Lafferty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Harrison Idaho
12. MAIDEN NAME OF MOTHER Helga Siverson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Ralph Lafferty
(Address) Kellogg - Ida -
15. Filed May 30, 1930 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch 22, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 15th, 1930, to March 22, 1930.
that I last saw him alive on Mar 22, 1930.
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia.
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms -
(Signed) W. C. Lindsay, M. D.
3/29, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Greenwood
Date of Burial Mch 25 1930
20. Undertaker M. C. Shawhill
Address Kellogg Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20718

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 10
Primary Registration District No. 1011
(No. Wallace Hospital) 161A
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

2. FULL NAME Maurice Dorithy

(a) Residence. No. Gem, Idaho St. Gem Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 12 - 1930

7. AGE Years	Months	Days	If LESS than 1 day, 2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER Wm Dorithy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Rose Hoggans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Wm Dorithy
(Address) Gem Idaho.

15. Filed May 13, 1930. L. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 13, 1930
that I last saw him alive on May 13, 1930
and that death occurred, on the date stated above, at 1:30 A. m.
The CAUSE OF DEATH* was as follows:
Immaturity (Premature birth)
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Nephritis (Large white kidney)
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? physical examination
(Signed) R. Diederich M. D.
May 13, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	May 13 1930
20. Undertaker J. A Bever Ward Und Co.	Address Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70719

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 53

101a

2. FULL NAME John Alfred Webster
(a) Residence. No. Burke Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 12 Months 2 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jardine Mont.

PARENTS
10. NAME OF FATHER A H Webster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) B. C.
12. MAIDEN NAME OF MOTHER Eliza Kirby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. J.

14. Informant Mrs A H Webster
(Address) Burke Idaho

15. Filed May 26, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 26 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1930 to May 26 1930
that I last saw him alive on May 26, 1930
and that death occurred, on the date stated above, at 7:00 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia
Lobular both lungs
(duration) ..... yrs. 4-5 mos. ..... ds.
CONTRIBUTORY (Secondary) Exposure
(duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) D. S. Monterey M.D.
5/26, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial May 24 1930

20. Undertaker Jas Bowen Ward Und Co. Address Wallace Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70726

PLACE OF DEATH
County of Shoshone
City of Near Wallace
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 52
(No.) 204
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Taylor
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ May Taylor
6. DATE OF BIRTH (month, day and year)
7. AGE 75 Years | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.
9. BIRTHPLACE (city or town) (State or country) New Brunswick

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mr George Campbell
(Address) Wallace, Idaho.
15. Filed May 24, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1930 (Year)
17. I HEREBY CERTIFY That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Found dead on dump of prospect
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis, Chr., Nutrition
Regurgitation Several
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) A. C. Mowary M. D.
5/19, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Tullman Wash | Date of Burial May 24 1930
20. Undertaker J. A. Bower Ward Und Co. | Address Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70731

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

HH

2. FULL NAME John Stevens
(a) Residence. No. Wallace Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Stevens.

6. DATE OF BIRTH (month, day and year) Nov-11-1871

7. AGE 48 Years | Months 6 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10. NAME OF FATHER Abraham Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Mrs Anna Stevens
(Address) Wallace, Ida.

15. Filed May 18, 1930. F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1930, to May 14, 1930
that I last saw him alive on May 14, 1930
and that death occurred, on the date stated above, at 6:30 P m.
The CAUSE OF DEATH* was as follows:
Adenocarcinoma of the Stomach
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Apr 2, 1930
Was there an autopsy? No
What test confirmed diagnosis? Physical examination
(Signed) R. R. Werlich, M. D.
May 16, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho. | Date of Burial May 18 1930

20. Undertaker J. A. Bever Ward Undt. Co. | Address Wallace Ida.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7[illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 10 11
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

31

2. FULL NAME A. H. Peterson

(a) Residence. No. Burke Idaho St. Burke, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	0	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hecla Mining Co

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Gust Johnson
(Address) Burke Ida

15. Filed May 17, 1930 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to May 14, 1930
that I last saw h— alive on May 14, 1930
and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:
Bilateral pulmonary tuberculosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) R. Wierich M. D.
May 14, 1930 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	May 17 1930.
20. Undertaker	Address
Bruce G. Worstell.	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70723

PLACE OF DEATH
County of Shoshone
City of Near Wallace
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 49
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

146

2. FULL NAME Max Barens
(a) Residence. No. Big Creek - Near Wallace
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Barens
6. DATE OF BIRTH (month, day and year): Jun 19 - 1891
7. AGE: Years 39 | Months 3 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Smoky Mine Co.
9. BIRTHPLACE (city or town) (State or country): Oklahoma

PARENTS
10. NAME OF FATHER: Abe. Barens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Clara Hilbert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Mrs Cora Barens
(Address): Osburn Ida.
15. Filed May 16, 1930 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on May 13 19.....
and that death occurred, on the date stated above, at 1:30 P.m.
THE CAUSE OF DEATH was as follows:
Coup Froce of Skull
Accidental
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Drowned in Settling Pond
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Dr. Robert Coroner 19..... (Address) Wallace Ida.
5/17/30

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Helena Montana — Date of Burial: May 19 1930
20. Undertaker: O. A. Bever — Address: Ward Und. Co. Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7025

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1611
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

2. FULL NAME Mary Isabelle Dickenson

(a) Residence. No. 1010a / Burke, Ida. St. Burke, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 26 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Ida

PARENTS
10. NAME OF FATHER Clyde J Dickenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Mable Diver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grangeville Idaho

14. Informant Clyde J Dickenson
(Address) Burke Ida

15. Filed May 12, 1930 F L Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 11, 1930
that I last saw her alive on May 11, 1930
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
Rt Lung all Lobes
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 5-6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Lora McGary, M. D.
5/12, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho	May 12 1930
20. Undertaker J. A Bever Work Und Co.	Address Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70725

PLACE OF DEATH
County of Teton
City of Felt

Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 8

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

77

2. FULL NAME Hazel May Price

(a) Residence. No. Felt Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of — (or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 11 – 1915

7. AGE: Years 14 | Months — | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) — —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Dillon, Mont

PARENTS

10. NAME OF FATHER L. T. Price.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pickens S C
12. MAIDEN NAME OF MOTHER Della Bonney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Akron Iowa

14. Informant Mrs Della M Long
(Address) Felt Ida.

15. Filed 5 – 5 – 1930 Martha M[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 – 4, 1930, to 5 – 4, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Strychnine poisoning (alkaloid)
..... (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
..... (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. T. Parkinson, M. D.
5 – 4 –, 1930 (Address) Driggs, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho | Date of Burial: 5 – 7 – 1930

20. Undertaker: Lewis Kiser | Address: Ashton

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7672

PLACE OF DEATH
County of Twin Falls
City of Twin Falls Co Hospital

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME Sarah Matilda Wilkinson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of A. E. Wilkinson

6. DATE OF BIRTH (month, day and year) June 28 - 1870

7. AGE: Years 59 | Months 10 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER J. C. Reams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Lucy Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant A. E. Wilkinson
(Address) Pasadena

15. Filed May 26, 1930 J. H. Worley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1929, to May 25, 1930
that I last saw her alive on May 23, 1930
and that death occurred, on the date stated above, at 4 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of May 20. 1930
Was there an autopsy? No
What test confirmed diagnosis? Physical.
(Signed) J. H. Worley, M. D.
May 26, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal: Buhl Ida — Date of Burial: 5/27/30

20. Undertaker: L. D. Johnson — Address: Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 10 1930

PLACE OF DEATH

County of Twin Falls

City of Buhl

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70727

Local Registrar's No. .....

182

2. FULL NAME Ernest Donald Rendla.

(a) Residence. No. 402 Taylor St — St. Twin Falls Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 11 1918

7. AGE Years 12 Months 4 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma.

PARENTS

10. NAME OF FATHER Adolph Rendla.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebr

12. MAIDEN NAME OF MOTHER Pauline Kropp

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebr.

14. Informant Adolph W Rendla.
(Address) Twin Falls Idaho

15. Filed 5-19, 1930 J. H. Wierfley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..

that I last saw h..... alive on Unattended, 19..

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning in Snake River while fishing

..... (duration) ..... yrs. ..... mos. ..... ds.

May 17/30 at about 11.40

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? — Date of — —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Drake, County Coroner

May 18, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery

Date of Burial 5/20 1930

20. Undertaker Merville D Rugg

Address Buhl Idaho

RECEIVED JUN 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70738

PLACE OF DEATH
County of Twin Falls
City of Rosewood
Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna May Strang
(a) Residence. No. Rosewood St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 26-1929

7. AGE Years Months 4 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rosewood

PARENTS
10. NAME OF FATHER Harvey Ray Strang
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Dorothy Mae Ray
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Buhl.

14. Informant (Address) H. R. Strang Rosewood

15. Filed 5-6, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found dead in bed. No
apparent Cause

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) J. H. Murphy Registrar, M. D.
5-6, 1930 (Address) Buhl

19. Place of Burial, Cremation, or Removal Buhl. Ida. Date of Burial 5/6 1930

20. Undertaker L. J. Johnson Address Buhl.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10799

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 37
Primary Registration District No. 2085
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Francis J. Huddleston 49

(a) Residence. No. Buhl Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 3 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	9	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Joel Huddleston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Nona Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant H. J. Huddleston
(Address) Filer Ida.

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 27, 1930
that I last saw him alive on May 26, 1930
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Epithelioma of neck.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
5/29, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer	May 29 1930
20. Undertaker	Address
T. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 76720

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

102c

2. FULL NAME William N. Wiseman

(a) Residence. No. 557 - 2nd W St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Wiseman

6. DATE OF BIRTH (month, day and year): Feb 5 - 1860

7. AGE: Years 70 | Months 3 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Walla Walla Wash

PARENTS

10. NAME OF FATHER: Tipton Wiseman

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Nancy Estes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ark

14. Informant: Mrs. Elizabeth Wiseman
(Address)

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-19, 19 , to , 19 that I last saw him alive on May 25th, 19 and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows: Psychosis following Right sided Pleurisy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Left sided Pleurisy

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Douglas, M. D.

5-26, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Walla Walla Wash | Date of Burial 19

20. Undertaker: White Mortuary | Address: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20731

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 159C

2. FULL NAME Baby Boyd
(a) Residence. No. 215 Ramage St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years — Months — Days — If LESS than 1 day, 9 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho
PARENTS
10. NAME OF FATHER E. F. Boyd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Okla
12. MAIDEN NAME OF MOTHER Willa J. Ireland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas
14. Informant E. F. Boyd
(Address) Twin Falls
15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to May 25, 1930
that I last saw her alive on May 24, 1938
and that death occurred, on the date stated above, at 4:00 A m.
The CAUSE OF DEATH* was as follows:
Congenital ~~inamnesia~~
small baby
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. E. Langenwalter, M. D.
May 25, 1930 (Address) Twin Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetery — Date of Burial: May 25 1930
20. Undertaker: T. C. Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 16232

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margarete Swansie

(a) Residence. No. 240 3rd Ave North St.
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alex Swansie.

6. DATE OF BIRTH (month, day and year): Dec. 8 1884

7. AGE: Years 46 | Months 5 | Days 17 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Omaha Neb.

PARENTS

10. NAME OF FATHER: William Simon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Alex Swansie
(Address) 240 3rd Ave No. city

15. Filed June 5th, 1930 Elizabeth G. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to May 25, 1930
that I last saw h[illegible] alive on May 24, 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Neuro Syphilis
General Paralysis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Probably Congenital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Chem. Lab.
(Signed) Dr John R Mangen M. D.
May 25, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: May 27 1930
20. Undertaker: T. J. Grossman — Address: Twin Falls

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48B

2. FULL NAME Margrett Thorney
(a) Residence. No. Elizabeth Blvd City St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Thorney

6. DATE OF BIRTH (month, day and year) Sept 5 1987

7. AGE Years 42 Months 8 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc.

PARENTS
10. NAME OF FATHER James Mash
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.
12. MAIDEN NAME OF MOTHER Katherine Healey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc

14. Informant Henry Thorney
(Address) Elizabeth Blvd. Twin Falls

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1926 to May 27, 1930
that I last saw her alive on May 27, 1930
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Chronic Valvular Heart disease
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) John L. Langham M. D.
5-27, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial May 27 1930

20. Undertaker P. J. Grossman Twin Falls
Address

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20724

PLACE OF DEATH
County of Twin Falls
City of Town of Murtaugh

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 2243

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1846

2. FULL NAME Louis L. Witham

(a) Residence. No. Oxford apptc St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Grace Witham

6. DATE OF BIRTH (month, day and year) Feb. 23, 1894

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	3	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck driver
(b) General nature of industry, business, or establishment in which employed (or employer) Hauling Produce
(c) Name of employer Pacific Fruit & Produce Co

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER John M. Witham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Vetta Edwards.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs Grace Witham
(Address) Twin Falls Ida

15. Filed May 24, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to May 23 1930
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
(1) Fracture frontal bone, right; depressed
(2) Fracture of base of skull
due to accident, automobile.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? accident occured in Cassia County
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Examination
(Signed) Geo C Halley Deputy coroner M. D.
May 24, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Baker, Oregon.	19
20. Undertaker	Address
J. C. Drake	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70735

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

wilson

74a

2. FULL NAME Virginia Hasson

(a) Residence. No. 782 - Main E. St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 13 - 1842

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	2	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER James Monford

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. E. P. Gregory

(Address) Boise Idaho

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to May 21, 1930

that I last saw her alive on May 21, 1930

and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. W. Wilson M. D.

May 21, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls

Date of Burial: 5 - 1930

20. Undertaker: White Mortuary Inc

Address: Twin Falls Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 9 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Twin Falls

City of Buhl

Registration District No. 37

Primary Registration District No. 2085

(No. ....., ... St.)

File No. 26736

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Zollie Bender Shockley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1907 (Year)

7. AGE: 23 Yrs. 3 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Hwfe

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Allen Fender

11. BIRTHPLACE OF FATHER (State or Country) N. C

12. MAIDEN NAME OF MOTHER Cora Shapard

13. BIRTHPLACE OF MOTHER (State or Country) N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Aubrey L Shockley

(Address) Buhl Idaho

15.

Filed June 6th 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

31

16. DATE OF DEATH: May (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1930, to May 16 1930, that I last saw her alive on May 16 1930, and that death occured on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Pul.)

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. Russell Weaver M. D.

5-16 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cemetery

DATE OF BURIAL: May 18 1930

20. UNDERTAKER: White Mortuary Inc

ADDRESS: Twin Falls. Ida.

SYMS - YORK CO., PTRS. & SDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 6232

PLACE OF DEATH
County Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Ruth Earhart (adopted by J. D. Earhart)

(a) Residence. No. Twin Falls RF D #3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	11	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kans.
(State or country)

PARENTS

10. NAME OF FATHER Walter Weaver
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Elva Suggle
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant J. D. Earhart
(Address) Twin Falls RF D #3

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26th, 1929 to May 13th, 1930
that I last saw her alive on May 13th, 1930,
and that death occurred, on the date stated above, at 11:40 P. m.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 18 mos. ds.
CONTRIBUTORY (Secondary) Tuberculosis of colon
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Hospital Laboratory

(Signed) John R. Quigley M.D.
5-15, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Hutchinson Kans.	
20. Undertaker	Address
J. E. Grosman	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20723

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1185
Local Registrar's No.
(No.) 159 E
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marjorie Lancaster
(a) Residence. No. Filer St. Dr Clausen
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write one word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,	hrs. or min.
	—	—	—	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Albert Lancaster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Ida Stewart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Albert Lancaster
(Address) Filer

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1930 3.40 PM
(Month) (Day) (Year)
May 12 1930

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 12, 1930
that I last saw her alive on May 12, 1930
and that death occurred, on the date stated above, at 3.40 P m.
The CAUSE OF DEATH* was as follows:
Atelectasis - enlarged thymus
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Clausen M. D.
May 12, 1930, (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sunset Memory Gardens	May 13 1930
20. Undertaker	Address
E Brink	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20229

PLACE OF DEATH
County Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Wm Lewis McClimans

(a) Residence. No. 160 Jackson St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 3 1857

7. AGE Years	Months	Days	If LESS than 1 day,
73	8	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER Wm McClamans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Maud J Chapman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Ira McClimans
(Address) 344 Van Buren.

15. Filed June 6 31, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to May 11, 1930
that I last saw him alive on May 11, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Hemorrhage, Cerebral
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Cardio-renal disease
(duration) Several mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C. Russell Weaver, M. D.
May 12, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 14 1930

20. Undertaker F. E. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20710

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1055
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry N. Slater

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) ~~Sept 5~~ May 14/*

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion

PARENTS
10. NAME OF FATHER J. Slater
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Sarah Page
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Harry Slater
(Address) Twin Falls

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h[illegible] alive on , 19
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis, probable
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral embolism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of May 11, 30
Was there an autopsy? No
What test confirmed diagnosis? Examination + investigation
(Signed) F. E. Drake Coroner
, 19 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	May 19
20. Undertaker F. E. Drake	Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Twin Falls

City of Rogerson

Registration District No. 37

Primary Registration District No. 2085

(No. at home)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

31

2. FULL NAME Anna Maud Helsley

(a) Residence. No. Rogerson Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 5 1913

7. AGE Years 17 Months 9 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Owhyee Co Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Jerome N. Helsley

11. BIRTHPLACE OF FATHER (city or town) Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Ora Curtis

13. BIRTHPLACE OF MOTHER (city or town) Ill.
(State or Country)

14. Informant Jerome N. Helsley
(Address) Rogerson Ida

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1928, to May 10, 1930

that I last saw her alive on May 7, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulm, Bilateral

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngeal

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray - Sputum positive

(Signed) D L Alexander, M. D.

5-13-30 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls

Date of Burial May 13 1930

20. Undertaker T J Grossman

Address Twin Falls

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70743

PLACE OF DEATH

County of Twin Falls.

City of Twin Falls.

Registration District No. 37

Primary Registration District No. 2081

Local Registrar's No.

(No. Twin Falls County Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME William Fridrich Dohse

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11 - 1915

7. AGE Years 14 Months 8 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimberly Ida

PARENTS

10. NAME OF FATHER J. F. Dohse

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Martha Rost

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Dakota

14. Informant J. F. Dohse
(Address) Kimberly Ida

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-3, 1930, to 5-8, 1930

that I last saw him alive on 5-8, 1930

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows: appendicitis (Rupt)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Kimberly Ida

Did an operation precede death? yes Date of 5-3-30

Was there an autopsy? no

What test confirmed diagnosis? operation & clinical

(Signed) J. K. Davis, M. D.

May 10, 1930 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Twin Falls Ida. Date of Burial 5-10 1930

20. Undertaker White Mortuary Inc Address Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1624

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 2085
(No. At home)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 164

2. FULL NAME Mrs. Charlotte Conover

(a) Residence. No. T F R F D St.
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 9 1849

7. AGE: Years 80 | Months 6 | Days 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: William Cogeshall
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Mary Biddlecom
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: M. C. Conover
(Address) Twin Falls R F D #2

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~June 15th~~, 1930, to May 7th, 1930
that I last saw h~~im~~ alive on May 7, 1930
and that death occurred, on the date stated above, at 2 30 p m.
The CAUSE OF DEATH* was as follows:

Senility (duration) 2 yrs. mos. ds.
@ CONTRIBUTORY (Secondary) Myocarditis acute - (duration) yrs. mos. 22 ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of
Was there an autopsy? No -
What test confirmed diagnosis? Clinical only.
(Signed) Duncan L Alexander, M. D.
5-8, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: May 9 1930
20. Undertaker: T. J. Grossman — Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70745

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Henry Pollendorf

(a) Residence. No. County Hospital St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 66 Years — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work County

(b) General nature of industry, business, or establishment in which employed (or employer) Indigent

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant No Records Available

(Address) County Coroner Twin Falls

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to May 6, 1930

that I last saw him alive on 5/6, 1930

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) (?) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.

5/8, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer-Cemetry — Date of Burial May 7 1930

20. Undertaker F E Drake — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Twin Falls
City of Twin Falls,

Registration District No. 37
Primary Registration District No. 2085
(No. County Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

71B

2. FULL NAME Edna Almeda Kaneaster
(a) Residence. No. 1305 Haybron ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 24th, 1919

7. AGE 11 Years 2 Months 11 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hagerman Ida.

PARENTS

10. NAME OF FATHER James O. Kaneaster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ga.
12. MAIDEN NAME OF MOTHER Ema E. Roberts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant James O. Kaneaster,
(Address) 1305 Habyron, Ave, Twin Falls,

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May. (Month) 6th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to May 6, 1930
that I last saw her alive on May 5, 1930
and that death occurred, on the date stated above, at 1.30 am m.
The CAUSE OF DEATH* was as follows:

Acute purulent meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 17 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture
(Signed) Charles K. Scott, M. D.
May 6, 1930 (Address) Twin Falls - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gooding Ida
Date of Burial May 7 1930

20. Undertaker P.J. Grossman,
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. Co Twin Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Edna Winifred Marrow
(a) Residence. No. 538 4 St. West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12 1921

7. AGE Years 9 Months 0 Days 23 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Glens Ferry Ida.

PARENTS
10. NAME OF FATHER James C Marrow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Fannie Van Laar
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ore

14. Informant James C. Marrow
(Address) 538 4 St. West.

15. Filed June 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to May 5, 1930.
that I last saw her alive on May 5, 1930.
and that death occurred, on the date stated above, at 3:30 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia, lobular.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis, glandular
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 538-4 St. W., Twin Falls, Id.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical & laboratory findings.
(Signed) W. F. Passer, M. D.
May 6, 1930 (Address) Twin Falls, Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Glens Ferry Ida — Date of Burial 5 7 6 1930
20. Undertaker J. F. Grossman — Address Twin Falls

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20243

PLACE OF DEATH
County of Twin Falls
City of Hollister
Registration District No. 37
Primary Registration District No. 2085
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. E. Smith
(a) Residence. No. Hollister St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 12

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Ellington Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER X X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) X X

14. Informant Mrs. Virgie Smith
(Address) Hollister

15. Filed June 5th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on May 5, 1930, to ~~1930~~, that I last saw him alive on 5/5, 1930 and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:
Uremia Coma
(duration) yrs. mos. 7 hrs.
CONTRIBUTORY (Secondary) Chronic nephritis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Reavis, M. D.
5/6, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	May 1930

20. Undertaker F. E. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

203-210

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1042

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. 750 2nd Ave North)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Frank Hann
(a) Residence. No. 750 2nd Ave North St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 28 1868

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Police Dept. (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Clayburn Hann
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER America James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Mrs Frank Hann
(Address) 750 2nd Ave North

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to May 2, 1930, that I last saw him alive on May 1, 1930, and that death occurred, on the date stated above, at 2:45 m.

The CAUSE OF DEATH* was as follows:
Hemmorrhage of the brain followed by a Stroke
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) H. W. Leeta, M. D.
5-3-, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gregorville Ill	19
20. Undertaker P. J. Grossman	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ellen Hamm
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. T. Hamm

6. DATE OF BIRTH (month, day and year) Oct 8th

7. AGE Years 72 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER A. E. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Rebecca Good
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dant Knox

14. Informant (Address) Mrs H. R. Beans Filer Ida

15. Filed June 5th, 1930 Elizabeth J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22, 1930, to April 30, 1930
that I last saw her alive on April 30, 1930
and that death occurred, on the date stated above, at 1 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Influenza

..... (duration) ..... yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Acute Endocarditis
..... (duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. W. Wilson, M. D.
May 3, 1930 (Address) Twin Falls Idaho

19. Place of Burial, Cremation, or Removal Filer Ida
Date of Burial 5-4 1930

20. Undertaker L. J. Johnson
Address Buhl Ida

23

RECEIVED JUN 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10253

PLACE OF DEATH
County of WASHINGTON
City of Cambridge
Registration District No. 88
Primary Registration District No.
(No.)
Local Registrar's No. 152
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Ball

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
			one hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) None.
(c) Name of employer None.

9. BIRTHPLACE (city or town) (State or country) Cambridge, Idaho.

PARENTS
10. NAME OF FATHER Celsus R. Ball
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon.
12. MAIDEN NAME OF MOTHER Erma Wooden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Council, Ida.

14. Informant
(Address)

15. Filed 6/6/30, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 (Month) 1930. (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/31/30, 19 to 5/31/30. 19
that I last saw her alive on 5/31/30. 19
and that death occurred, on the date stated above, at 10:00 A. m.
The CAUSE OF DEATH* was as follows:
Congenital Atalectasis.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Premature birth at 6th month of gestation.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) M. D.
6/6/30, 19 (Address) Cambridge-Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cambridge, Ida.	5/32/30. 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

70752

RECEIVED JUL 1 193(

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70752

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 164
(No. 205 N. 14th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

19

2. **FULL NAME** Fred A. Bailey.

(a) Residence. No. 205 N. 14th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hazel Bailey.

6. DATE OF BIRTH (month, day and year) October 29th 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clear Mount, Mo.

PARENTS

10. NAME OF FATHER James H. Bailey.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Rose Landers.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant Mrs. F. A. Bailey.
(Address) Boise, Idaho.

15. Filed 6-2, 1930 W. R. Clarke Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19--, to ----------, 19--, that I last saw ~~him~~ alive on ----------, 19--, and ~~that~~ death occurred, on the date stated above, at 3:15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accidently fell striking his head on the corner of a Dresser Knocking himself unconscious, in which state he died (duration) yrs. mos. ds. He was dead when friends lifted him onto a bed a few minutes later.

CONTRIBUTORY (Secondary) (duration) Was large man weighing about 216 pounds. yrs. mos. ds.

18. Where was disease contracted if not at place of death? No Inquest held.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm McBratney - Coroner M. D.
5/28/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	5/29/30 19.

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 1 1930

70753

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70753

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise,

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 129
(No. Boise, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Leland Lamb.

(a) Residence. No. 2309 N. 20th St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ethel Lamb

6. DATE OF BIRTH (month, day and year) August 3rd 1892

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	10	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Building Contractor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lehi, Utah.

PARENTS

10. NAME OF FATHER James E. Lamb.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lehi, Utah.

12. MAIDEN NAME OF MOTHER Etta Losee.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lehi, Utah

14. Informant Mrs. Ethel Lamb.
(Address) Boise, Idaho.

15. Filed 6-28, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..., 19..., to ..., 19...
~~that I last saw he~~ alive on ..., 19...
~~and that~~ death occurred, on the date stated above, at 11:00P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accidently Shot with 12 Ga. Shotgun. Was taking Shotgun out of Auto when it was accidently discharged the load entering the abdomen about 2" below the navel. Death occured about 20 minutes later.

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No Inquest held.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed ~~diagnosis~~?

(Signed) Wm. McBratney Coroner
6/23/30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6/24/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

70754

DO NOT WRITE IN THIS SPACE
State File No. 70754

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 33

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No. 101A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William N. Bush

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of
x x x

6. DATE OF BIRTH (month, day and year) June 15, 1910

7. AGE: Years 20 | Months — | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Crescent Mng Co.

9. BIRTHPLACE (city or town) (State or country): Strathmore Alberta Canada

PARENTS

10. NAME OF FATHER: Wm. S. Bush
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Martha Anna Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: W. S. Bush
(Address): Creston, B.C.

15. Filed June 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1930 (Year).

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 21, 1930
that I last saw h[illegible] alive on June 21, 1930
and that death occurred, on the date stated above, at 7 p. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical.

(Signed) F. W. Laraway, M. D.
7-1-, 1930 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg, Idaho — Date of Burial: June 23, 1930
20. Undertaker: M. C. Trumbull — Address: Kellogg, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

70755

DO NOT WRITE IN THIS SPACE
State File No. 70755

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
Local Registrar's No. 36

(If death occurred in a hospital or institution, give its name instead of street and number) Wardner Hospital

101a

2. FULL NAME Edward John Donahue

(a) Residence. No. 214 Gold ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ruth Hodge

6. DATE OF BIRTH (month, day and year) May 27-1895

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. N. S. Co

9. BIRTHPLACE (city or town) (State or country) Mackay Ida

PARENTS

10. NAME OF FATHER Thomas Donahue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Hannah McKelvie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Hannah Donahue
(Address) Kellogg Ida

15. Filed June 30, 1930 Miss Helen M Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-5-, 1930, to 6-8-, 1930
that I last saw him alive on 6-8-, 1930
and that death occurred, on the date stated above, at 8 p. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia.

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? residence.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) F. V. Laraway M. D.
6-9-, 1930. (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mackay Ida	
20. Undertaker R. V. Saul	Address Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

70756

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70756

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 169
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

95

2. **FULL NAME** Henry Rebmann.

(a) Residence. No. 1107. Howard. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Ruth Cory Rebmann.

6. DATE OF BIRTH (month, day and year) May. 13.1894.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	0	21.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER Henry Rebmann.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant (Address) Mrs. Ruth Cory Rebmann. R.D. # 5. Boise, Idaho.

15. Filed 6-7, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day), 1936 (Year)

17. I HEREBY CERTIFY, That I attended deceased from not at all, 19 to 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage from Lungs

(duration) yrs. mos. 10 min ds.

CONTRIBUTORY (Secondary) ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) O H Richer, M. D.
, 19 (Address) Boise, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	June. 7. 30.
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

70757

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70757

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 23

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Robert Seifert

(a) Residence. No. 338 - Second St St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Seifert

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	2	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer CM & St P - RR Co

9. BIRTHPLACE (city or town) (State or country) ~~Australia~~ Austria

PARENTS

10. NAME OF FATHER Joseph Seifert

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Australia~~ Austria

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ~~Australia~~ Austria

14. Informant Josephine Seifert
(Address) St Maries Ida

15. Filed 6-23, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows: accidentally killed by R.R. train

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G. G. Espe, Coroner, M. D.

6/25/30, 19..... (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: June 26 1930

20. Undertaker: Geo E. Mitchell
Address: St Maries

RECEIVED JUL 10 1930

Issued 7075-8

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70758

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5-860

PLACE OF DEATH

County of Bannock

City of Pocatello

(No.) St Anthony Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Myrtle Pattis

(a) Residence. No. 406 S 6th St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of John Pattis

6. DATE OF BIRTH (month, day and year) July 15-1892

7. AGE: Years 37 | Months 11 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Ida

PARENTS

10. NAME OF FATHER M L Pirkey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) [illegible]

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Pattis

(Address) Pocatello Idaho

15. Filed 7-7-1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1/30, 19..., to 7/6/30, 19..., that I last saw h[illegible] alive on 7/6/30, 19..., and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/7, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	7/9 1930
20. Undertaker	Address
J Schumacher & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 10 1930

7075-9

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70759

PLACE OF DEATH
County of Shoshone
City of Marble Cr

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 25

(No. 149) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore N. Winnington

(a) Residence. No. 1223 E. Rowan St. St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Vera A. Winnington

6. DATE OF BIRTH (month, day and year) Oct. 18, 1895

7. AGE	Years	Months	Days	If LESS than 1 day,
	34	8	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rutledge Timber Co.

9. BIRTHPLACE (city or town) (State or country) Alpena, No. D.

PARENTS

10. NAME OF FATHER Thomas W. Winnington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER C. Royds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Rev. E. Mitchell
(Address) St. Maries, Ida.

15. Filed June 30, 1930 Walter Cokers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows: accidentally killed by a log.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?

(Signed) G. G. Espe Coroner, M. D.
6/30, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cem. Spokane, Wn	July 3 1930
20. Undertaker Hagen & Jaeger Rev E. Mitchell	Spokane, Wn St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 28 1930

707-9

E 2617 Post St.
Spokane, Washington
July 26, 1930

Dept. of Public Welfare
State of Idaho
Boise, Idaho.

Gentlemen:

I am returning copy of death certificate made out if favor of Mr. Thomas Winnington, and have listed below the correct information that should appear on this certificate. It is very necessary that this be filled out correctly as it is to be sent to the United States Ware Department to enable the widow to collect the army insurance carried by her husband. I am writing in behalf of Mrs. Theodore Winnington who resides at E 1223 Rowan Ave., Spokane, Wash.

In the first place this man's name was Theodore N. Winnington and not Thomas. I have listed other corrections below:

Worked at Clarke since April 1930, Lived in Spokane, Wn
Married since 1919
Wife's name Vera A. Winnington
Date of Birth October 18, 1895
Age 34 yrs 8 mos. 10 das. at death
Birthplace Alpena, N. D.
Name of Father Thomas W. Winnington
Birthplace of Father England
Maiden Name of Mother C. Royds
Birthplace of Mother England
Burial took place at Greenwood Cemetery, Spokane, Wn.
July 3, 1930
Undertaker Hazen & Jaeger, Spokane
Geo. E. Mitchell St. Maries.

Wish you would please maid revised death certificate to Mrs. Theodore Winnington, E 1223 Rowan Ave. Spokane, Wash.

Thanking you, I remain

Very truly yours, Duncan A. McLeod

70760

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70760

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 24
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

89

2. FULL NAME Mary Stone
(a) Residence. No. 325 - 5th St St Maries St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Gus. Stone

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 55 | Months 4 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Olof Olson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Maria Olson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Mrs Hebert Clough
(Address) 3111 E 35th St Spokane Wash

15. Filed 6-30, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-24, 1930, to 6-25, 1930
that I last saw her alive on 6-25, 1930
and that death occurred, on the date stated above, at 10 30 a. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. G. Esp, M. D.
6/30, 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: June 29 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

70761 White

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70761

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 1842 Main Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Della I. Robertson.

(a) Residence. No. 1842 Main St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: T. H. Robertson.

6. DATE OF BIRTH (month, day and year): Mar 15th, 1874.

7. AGE: Years 56. Months 3. Days 0. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Benjiman Terwillegar.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Mary Ann Pettingill.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wisconsin.

14. Informant:

(Address) Lewiston, Idaho.

15. Filed 6-18, 1930 J M - Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15th, 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to June 15, 1930 that I last saw her alive on June 14, 1930 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: acute dilatation of Heart (myocarditis)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Cholocystitis + gallstones

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.

6/16/30., 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 6/16/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 15 1930

70762

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70762

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

108C

2. FULL NAME Charles Frank Powers
(a) Residence. No. Pocatello Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb. 12 1878
7. AGE: Years 52, Months 4, Days 24. If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lineman
(b) General nature of industry, business, or establishment in which employed (or employer) Electrician
(c) Name of employer Idaho Power Co.
9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER James N Powers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Mattie Pinckley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Tuyla Powers
(Address) Pocatello Ida

15. Filed July 14th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 6, 1930
that I last saw him alive on July 6, 1930
and that death occurred, on the date stated above, at 8:10 P.m.
The CAUSE OF DEATH* was as follows:
Brain Traumatism - without fracture - Auto-accident
(duration) ___ yrs. ___ mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 6.
Was there an autopsy? Decompression
What test confirmed diagnosis? No Operation
(Signed) Duncan L Alexander D.
July 7, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: 7/10 1930
20. Undertaker: [illegible] Gosander
Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

70763

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70763

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 57
129

PLACE OF DEATH
County of Ada.
City of Boise.
(No. Boise, Idaho Route #1.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Edwin Lewis Chamberlain.

(a) Residence. No. Boise, Idaho. Route #1. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Chamberlain

6. DATE OF BIRTH (month, day and year) August 19th 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Danelsonville, Conn.

PARENTS
10. NAME OF FATHER Lewis Chamberlain.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Danelsville, Conn.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Conn.

14. Informant (Address) Mrs. E. L. Chamberlain. Boise, Idaho.

15. Filed 7-16, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1929, to July 13 1930
that I last saw him alive on July 13 1930
and that death occurred, on the date stated above, at 9:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Nephritis - (Diabetes)

(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetes.
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clin. & Physical

(Signed) Oswald T. Rhodes, M. D.
7/15/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7-15 1930
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70764

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 9
Primary Registration District No. 1004 Local Registrar's No. 159
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Mrs. Ellen Ruth Neely.

(a) Residence. No. 2304 N. 14th St.
(Usual place of abode.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dan Neely.

6. DATE OF BIRTH (month, day and year) November 1889

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	6		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario, Canada.

PARENTS

10. NAME OF FATHER Samuel Ansley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Phillipi Langman.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Canada.

14. Informant Dan Neely.
(Address) Boise, Idaho.

15. Filed 6-2, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 29, 1930, that I last saw h... alive on May 19, 1930, and that death occurred, on the date stated above, at 11:20 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uterine Hemorrhages
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Miscarriage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Barth M. D.
May 31, 1930. (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 6/2/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70765

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 158
(No. 1115 Oakland Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Catherine Wacker
(a) Residence. No. 1115 Oakland St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 29 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wacker.

6. DATE OF BIRTH (month, day and year) May 6th 1876

7. AGE Years 54 Months 0 Days 22 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boda, Sweden

PARENTS

10. NAME OF FATHER August Sell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweden

14. Informant (Address) Harold Anderson. ~~Boise, Idaho~~

15. Filed 6-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ~~19~~ ~~to~~ ~~19~~ ~~that I last saw h~~ ~~alive on~~ ~~19~~ ~~and that~~ death occurred, on the date stated above, at ___ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Suicide. Hung herself by the neck.
Found Dead.
(duration) yrs. mos. ds.
No Inquest held.
CONTRIBUTORY (Secondary) Probably Insane.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ___
Did an operation precede death? No. Date of ___
Was there an autopsy? No.
What test confirmed diagnosis? ___
(Signed) W. McBratney, Coroner ~~M. D.~~
5/28/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 6/1/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70766

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 53
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Ownbey.
(a) Residence. No. One Half mile North of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jackson Ownbey.

6. DATE OF BIRTH (month, day and year): Feb. 22. 1869.

7. AGE: Years 61. Months 4 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas.

PARENTS
10. NAME OF FATHER: Martin Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Rebekah Silvers.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown.

14. Informant (Address): Jackson Ownbey. R.D.#3. Boise, Idaho.

15. Filed 6-28, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 —, 1930, to June 27, 1930
that I last saw her alive on June 26, 1930
and that death occurred, on the date stated above, at 1 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Progressive Bulbar Paralysis
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) High Blood Pressure - Arteriosclerosis
(duration) yrs. ✓ mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) M. Caccaway Jupiter, M. D.
June 27, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery.
Date of Burial: June. 30 1930

20. Undertaker: Summers & Krebs.
Address: Boise, Ida.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70767

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 52

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

97

2. FULL NAME ALVA E. HUDSON

(a) Residence. No. Lewiston, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	2	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER --

11. BIRTHPLACE OF FATHER (city or town) (State or Country) --

12. MAIDEN NAME OF MOTHER --

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) --

14. Informant H. Book

(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 6-24, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to June 20, 1930
that I last saw him alive on June 20, 1930
and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

(duration) (Immediate) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema, draining

(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? --

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory tests

(Signed) C. L. Magruder M. D.
C.L. MAGRUDER, Act. Reg. Med. Off.
June 24, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kendrick, Idaho	June 26 1930

20. Undertaker Wm. McBratney. Address Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70768

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 49
(No. Ada County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. **FULL NAME** William LeRoy
(a) Residence. No. 304 Grove St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) February 5th 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) John Miller. Boise, Idaho.

15. Filed 6-13, 1930 W. S. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 9, 1930
that I last saw him alive on June 9, 1930
and that death occurred, on the date stated above, at 7 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senile dementia
Heart trouble

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. Fren[illegible], M. D.
6/12/30, 19 (Address) Bo[illegible], Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 6/13/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JUL 9 1930

PLACE OF DEATH

County of Ada.

City of Boise.

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70769

Registration District No. 8

Primary Registration District No. 2004 Local Registrar's No. 48

(No. Ada County Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Martha Frances Green.

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Green.

6. DATE OF BIRTH (month, day and year) July 23rd 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	10	12	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10. NAME OF FATHER -----McCandless.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Frances Butler.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant Ross Green.
(Address) Grimes Pass, Idaho.

15. Filed 6-11, 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~, to ~~, 19~~

~~that I last saw h~~ alive on ~~, 19~~

~~and that~~ death occurred, on the date stated above, at 5:30A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~~~~

Did an operation precede death? No. Date of ~~~~

Was there an autopsy? No. ~~~~

What test confirmed diagnosis? ~~~~

(Signed) Wm McBratney, Coroner, ~~M. D.~~

6/6/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6-11-30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7077 0

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 47
(No. Maple Grove Road)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Parkin
(a) Residence. No. Meridian St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 4. 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	4	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Northumberland England

PARENTS

10. NAME OF FATHER Matthew Parkin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Matilda Waggett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Co Durham England

14. Informant Mrs John Parkin
(Address) Boise Idaho R. F. D. 4.

15. Filed 6-6, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 5, 1930
that I last saw h in alive on May 12, 1930
and that death occurred, on the date stated above, at 2.50 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) 10+ yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) A. W. Beach M. D.
June 6, 1930 (Address) Boise Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Boise	June 8 1930
20. Undertaker	Address
W. S. Molter	Meridian Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70772

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 172
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

186

2. FULL NAME Leo Untermahrer
(a) Residence. No. St. Idaho City
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 39 yrs. — mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1865

7. AGE 65 Years | Months | Days | If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Blain
(c) Name of employer Franklin Placer Co.

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS
10. NAME OF FATHER Anton Untermahrer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Anna Schlaefle
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Switzerland

14. Informant (Address) Anton Untermahrer Boise Ida

15. Filed 6-9, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th, 1930, to June 6th, 1930
that I last saw him alive on June 6th, 1930
and that death occurred, on the date stated above, at 9.27 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accident while mining death due to internal injuries. —
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) —
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John Bouk, M. D.
June 7th, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal St. John's Cemetery | Date of Burial 6/9 1930

20. Undertaker Schreiber & McCann | Address Boise

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70773

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 171
(No. 1115 N. 10th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Fred E. James.

(a) Residence. No. 1115 N. 10th St.
(Usual place of abode.)
Length of residence in city or town where death occured. 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Zylpha James.

6. DATE OF BIRTH (month, day and year) February 12th 1872

7. AGE Years	Months	Days	If LESS than 1 day, ~~hrs.~~ or ~~min.~~
58	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Brand Recorder.
(b) General nature of industry, business, or establishment in which employed (or employer) Dept. of Agriculture.
(c) Name of employer State House.

9. BIRTHPLACE (city or town) (State or country) Mankato, Minn.

PARENTS

10. NAME OF FATHER Richard James.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Armena Smead.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y.

14. Informant Mrs. Nellie Davis.
(Address) Filer, Idaho.

15. Filed 6-9, 1930 W. L. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~, to ~~, 19~~
~~that I last saw him~~ alive on ~~, 19~~ and that death occurred, on the date stated above, at about 9:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:
Took a severe pain in the region of his heart and died in a few minutes. Had been subject to these pains for years (duration) yrs. mos. ds.
Natural cause - No Inquest held.
CONTRIBUTORY (Secondary) Probably acute indigestion was (duration) yrs. mos. ds.
partly the cause.

18. Where was disease contracted if not at place of death? ~~~
Did an operation precede death? No. Date of ~~~
Was there an autopsy? No.
What test confirmed diagnosis? ~~~

(Signed) Wm. McBratney, Coroner, ~~M. D.~~
6/6/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill	6-10-30 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70774

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 170

(No. 1902 N. 18th street.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Verner Tingley

(a) Residence. No. 1902 N. 18th Street. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Georgie Tingley

6. DATE OF BIRTH (month, day and year) July 29th 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dredgeman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Green Castle, Ind.

PARENTS

10. NAME OF FATHER Joseph Tingley.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ellen R. Webb.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant Joe Tingley.
(Address) Boise, Idaho.

15. Filed 6-9, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 6, 1930
that I last saw him alive on June 5, 1930
and that death occurred, on the date stated above, at 2 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Splenic Leukemia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris T

Myocarditis (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) J. Reno Numbers, M. D.

6/6/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6/9/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70775

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 168
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

177

2. **FULL NAME** Mrs. Sadie A. Potts.

(a) Residence. No. 411 South 3rd St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Albert L. Potts.

6. DATE OF BIRTH (month, day and year) May 7th 1874.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	0	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER ------Powell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER -------Bloxom.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tenn.

14. Informant A. L. Potts.
(Address) Boise, Idaho.

15. Filed 6-6, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1930, to June 5 1930
that I last saw h.e. alive on June 5 1930
and that death occurred, on the date stated above, at 4:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Poisoned by overdose of calomel - accidental

(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Acute nephritis & heart failure (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. O. Beach M. D.
6/5/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill--Caldwell.	6/8/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70776

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 167

(No. 1113)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George William Harrison.

(a) Residence. No. 1014. N. 10 Street. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April. 19. 1849.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81.	1.	13.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Greencastle.
(State or country) Indiana.

PARENTS

10. NAME OF FATHER Robert Harrison.

11. BIRTHPLACE OF FATHER (city or town) Kentucky.
(State or Country)

12. MAIDEN NAME OF MOTHER Catherine Wray.

13. BIRTHPLACE OF MOTHER (city or town) Indiana.
(State or County)

14. Informant Robert. S. Harrison.
(Address) 1014. N. 10 St, Boise, Idaho.

15. Filed 6-6, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.... to ....., 19....
that I last saw h~~im~~ alive on June 1, 1930
and that death occurred, on the date stated above, at 10:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hemorrhage from Duodenal Ulcer

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Fred A. Wheeler, M. D.

6/4, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Claronda Jones — Date of Burial: June 6, 1930

20. Undertaker: Summers & Krebs. — Address: Boise, Idaho

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70777

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 766
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Gay Brown
(a) Residence. No. St Alphonsus Hospital St. Nampa Ida 1002
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Feb 19th 1930
7. AGE Years Months Days 13 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Nampa Idaho

PARENTS
10. NAME OF FATHER L. S. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or County) [illegible]

14. Informant (Address) Mrs. Mady Brown Nampa, Idaho
15. Filed 6-6, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930 to June 2, 1930
that I last saw her alive on June 2, 1930
and that death occurred, on the date stated above, at 3:40 p.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Pneumococcic rhinitis
Probable (duration) yrs. 1 mos. ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of May 31 30
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Harmon Tremaine M. D.
June 2, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 6-4 1930
20. Undertaker Mrs Nina N. Valley
Address Nampa, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Stewart

DO NOT WRITE IN THIS SPACE
State File No. 70778

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 165
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

14 B

2. FULL NAME James Edward Eshom
(a) Residence. No. Weiser Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Eshom

6. DATE OF BIRTH (month, day and year) Aug 13-1858

7. AGE 71 Years Months 9 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman & Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Wm Eshom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Luanna Folbrah
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dont Know

14. Informant (Address) Mrs J E Eshom Weiser Idaho

15. Filed 6-5, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14, 1930 to June 3, 1930
that I last saw him alive on June 3, 1930
and that death occurred, on the date stated above, at 7 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Toxic Goitre
Myocarditis
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Weiser Idaho
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical Laboratory Co
(Signed) James L. Stewart, M. D.
June 4, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery Date of Burial 6-5-1930

20. Undertaker L. C. Northam Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70779

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 163
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Albert Henry Dudenbostel.
(a) Residence. No. 1310. N. 12 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna. M. Dudenbostel.

6. DATE OF BIRTH (month, day and year) June. 7. 1884.

7. AGE Years 45. Months 11 Days 26. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Groceryman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chester Ill.

PARENTS
10. NAME OF FATHER Louis Dudenbostel.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Mary Knapp.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois.

14. Informant (Address) Mrs. Anna. M. Dudenbostel. 1310. N. 12 Street, Boise, Idaho

15. Filed 3, 1930 W. V. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1215 a.m. 1930, to 1.15 a.m. 1930
that I last saw him alive on June 3, 1930
and that death occurred, on the date stated above, at 1.15 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis

5 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) H. M. Howerson, M. D.
June 4, 1930 (Address) Boise.

19. Place of Burial, Cremation, or Removal Chester Illinois
Date of Burial June 8 1930

20. Undertaker Summers & Krebs.
Address Boise, Idaho

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70780

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1094
Local Registrar's No. 162
(No.) St Lukes Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jessie Marie McCleigh

(a) Residence. No. 519 S. 16 St.
(Usual place of abode.)
Length of residence in city or town where death occured 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Roderique B McCleigh

6. DATE OF BIRTH (month, day and year) April 29 1910

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	1	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Manard Idaho

PARENTS
10. NAME OF FATHER Charles B Bonup
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Isabel Wray
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Minnesota

14. Informant (Address) Charles B Bonup 519 S. 16 St. Boise Idaho

15. Filed 6-3, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th, 1930 to May 30th, 1930
that I last saw her alive on May 30th, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Lung Tubercular Abscess.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 28th 30
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) [signature] M. D.
June 2nd, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: June 2 1930
20. Undertaker: Summers & Trefz — Address: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70781

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 161
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Josephene Mary Carr.
(a) Residence. No. 1003. N. 6 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John. E. Carr.

6. DATE OF BIRTH (month, day and year) April. 16.1856.

7. AGE Years 74. Months 1 Days 15. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelton, Ill.

PARENTS

10. NAME OF FATHER John. C. Wyatt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant (Address) Mrs. Josephene Grebe. 1003. N. 6 Street, Boise, Idaho.

15. Filed 6-3, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb - 26, 1930, to 6-1, 1930
that I last saw her alive on 6-1, 1930
and that death occurred, on the date stated above, at 3 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) [signature] M. D.
6/2, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: June.3.30.

20. Undertaker: Summers & Krebs.
Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70782

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 190
(No. 2110 Bannock st.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Irene Annabell Gaddis.
(a) Residence. No. Gooding, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 16 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) May 7th 1930

7. AGE Years 0 Months 1 Days 23 If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gooding, Idaho.

PARENTS
10. NAME OF FATHER John C. Gaddis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Gladys Steinkopf.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Council Bluffs Ia.

14. Informant (Address) George Steinkopf. Boise, Idaho.

15. Filed 6-30, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to June 30, 1930 that I last saw her alive on June 29, 1930 and that death occurred, on the date stated above, at 8:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Malignant Jaundice

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) M. Greenway-Joplin, M. D.
6/30/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Gooding, Idaho. Date of Burial 7/1/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70783

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 188
(No. Salvation Army Rescue Home) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Delpha June Combs

(a) Residence. No. Boise, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) June 22nd 1930

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or ---------- min.
0	0	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER William Berry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Hazel Combs.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant Hazel Combs.
(Address) Emmett, Idaho.

15. Filed 6-26, 19 30 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 25, 1930,
that I last saw her alive on June 25, 1930,
and that death occurred, on the date stated above, at 10 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Congenital Obstruction to Bowels

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Attorney, M. D.
6/26/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6/26/30 19

20. Undertaker Wm. McBratney. Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Wahle

DO NOT WRITE IN THIS SPACE

State File No. 20784

PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 3

Primary Registration District No. 1004 Local Registrar's No. 187

(No. St Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. **FULL NAME** George Schweitzer.

(a) Residence. No. 412. S. 5 Street. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 34 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lulu. M. Schweitzer.

6. DATE OF BIRTH (month, day and year) December. 14. 1860.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69.	6	10.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pennsylvania. (State or country)

PARENTS

10. NAME OF FATHER George Schweitzer.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Catherine Sunday.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant Mrs. Lulu. M. Schweitzer.
(Address) 412. S. 5 Street, Boise, Idaho.

15. Filed 6-25, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 24, 1930, that I last saw him alive on June 23, 1930, and that death occurred, on the date stated above, at 7 30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Toxemia
Thrombosis of Both
femoral arteries & gangrene
of both lower limbs
(duration) yrs. mos. ds.
Toxemia Myocardial Degeneration
CONTRIBUTORY (Secondary) and arteria sclerosis
Nephritis (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? General condition & examination
(Signed) J. H. Wahle, M. D.
, 19 (Address) 515 Eastman Bldg Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: June 26, 1930

20. Undertaker: Summers & Krebs. Address: Boise, Ida.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 20785

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 186

96B

2. **FULL NAME** Stanley Gordon Smith

(a) Residence. No. 139 Warm Springs Ave St.
(Usual place of abode.)
Length of residence in city or town where death occured. 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	married

5a. If married, ~~widowed, or divorced~~
HUSBAND of (or) ~~WIFE of~~ Bella Jack Smith

6. DATE OF BIRTH (month, day and year) 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Engineer and Treasurer Oxy Metals
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ottawa, Canada

PARENTS

10. NAME OF FATHER Jacob Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER not obtainable now
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Leo J Jack Boise Idaho

15. Filed 6-25, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21, 1930, to 6/18, 1930, that I last saw him alive on 6/18, 1930, and that death occurred, on the date stated above, at 7 PM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mastoid with Labyrinthian infection Meningitis

(duration) yrs. mos. 22 ds.
CONTRIBUTORY (Secondary) Mastoid
(duration) yrs. mos. 22 ds.

18. Where was disease contracted if not at place of death? Boise
Did an operation precede death? yes Date of 16 June
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H Jones, M. D.
(Address)

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery	6/20 1930
20. Undertaker: Schreiber & McCann	Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70786

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 185
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

6-B

2. FULL NAME William Gerald Van Horn.

(a) Residence. No. Mayfield, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hazel Van Horn.

6. DATE OF BIRTH (month, day and year) October 23rd 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Theodore Van Horn.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Essie Stotts.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) Mrs. Will Baker. Boise, Idaho.

15. Filed 6-23, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-20, 1930, to June 20, 1930
that I last saw him alive on June 20 1930
and that death occurred, on the date stated above, at 8:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? yes

(Signed) Chas. J. Sweeney, M. D.
6/21/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 6/22/30, 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70787

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 184

(No. St. Lukes Hospital.) 49

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Soloman S. Myers.

(a) Residence. No. Council, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella Myers.

6. DATE OF BIRTH (month, day and year) March 1st 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	3	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stone County, Mo.

PARENTS

10. NAME OF FATHER Benj. Myers.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Elizabeth---------

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant Frank T. Myers.
(Address) Council, Idaho.

15. Filed 6-20, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 18, 1930
that I last saw h.m alive on June 18, 1930
and that death occurred, on the date stated above, at 10 A.M.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of pancreas

about 4
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of April 17 30
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) A. O. Bonk M.D. M. D.
6/19/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Council, Idaho.	Shipped 6/20/30 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70788

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 183
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Ellis. E. Smith.
(a) Residence. No. 1116. N. 9 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Rose. H. Smith.

6. DATE OF BIRTH (month, day and year): September.14.1883.

7. AGE: Years 46. Months 9. Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Manager of Boise Water Co.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS
10. NAME OF FATHER: Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown.

14. Informant (Address): Mrs. Rose. H. Smith. 1116. N. 9 Street. Boise, Idaho.

15. Filed 6-20, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 19, 1930 that I last saw him alive on June 19, 1930 and that death occurred, on the date stated above, at 10:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pharyngeal abscess.
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A. B. Borck, M. D.
June 19, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Joliet, Ill. Date of Burial: June. 24. 1930.

20. Undertaker: Summers & Krebs. Address: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

PLACE OF DEATH

County of Ada

City of Boise.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70789

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 182

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. **FULL NAME** Sarah Belle Romans.

(a) Residence. No. 2724. Idaho Street. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January. 7.1853.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77.	5.	10.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER Hugh. H. Wilson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Mary Hamilton.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) Mrs. A.I. Owen. 2724. Idaho. St Boise, Idaho.

15. Filed 6-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th, 1930, to June 17th, 1930 that I last saw her alive on June 16th, 1930 and that death occurred, on the date stated above, at 9.30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia and apoplexy.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertension of arteries and former cranial remorrhage

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Bank, M. D.

June 17, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Greeley, Colorado.	June.20.30.

20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7079

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 19
(No. 1107 O'Farrell Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. **FULL NAME** Mrs. Grace Johnesse Workman.

(a) Residence. No. 1107 O'Farrell St.
(Usual place of abode.)
Length of residence in city or town where death occured. 34 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis E. Workman

6. DATE OF BIRTH (month, day and year) May 27th 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	0	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montrose, Iowa.

PARENTS

10. NAME OF FATHER William N. Johnesse.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Port Huron, Mich.
12. MAIDEN NAME OF MOTHER Adaline Johnson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wheeling, W. Va.

14. Informant (Address) Mrs. Frank Johnesse. Boise, Idaho.

15. Filed 6-17, 1930 W. H. Clarke Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to June 15, 1930
that I last saw her alive on June 14, 1930
and that death occurred, on the date stated above, at 12:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus.
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Consultation

(Signed) F. H. Truston, M. D.
June 16, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6/17/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70791

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 18
(No. 1904 West Bannock St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred R. Herrick

(a) Residence. No. 1904 W. Bannock St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

45

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Della E. Herrick.

6. DATE OF BIRTH (month, day and year) October 16th 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	6	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER Loren P. Herrick.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER Louise Heacock.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y.

14. Informant (Address) Mrs. Della E. Herrick. Boise, Idaho.

15. Filed 6-17, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to June 16, 1930
that I last saw him alive on June 15, 1930
and that death occurred, on the date stated above, at 12:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum

(duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? Yes Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) M. Cassaway-Joplin, M. D.
6/17/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 6/19/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70792

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 . Local Registrar's No. 179
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kate Kramer Burns.
(a) Residence. No. 1309. State Street. St. 90
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred. P. Burns.

6. DATE OF BIRTH (month, day and year) Dec.2.1850.

7. AGE Years 79. Months 6. Days 13. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS
10. NAME OF FATHER Daniel Kramer.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Mary Booth.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant (Address) A.P. Burns. 1309. State Street, Boise, Idaho.

15. Filed 6-17, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to 6/15, 1930
that I last saw her alive on 6/15, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Vascular Degeneration

(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) Fred A. Pettingill, M. D.
6/16, 1930 (Address) Boise Id

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial June 17 1930

20. Undertaker Summers & Krebs. Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JUL 9 1930

DO NOT WRITE IN THIS SPACE
State File No. 70793

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 178
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Charles W. Gilmer.
(a) Residence. No. Mayfield, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Divorced.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE: About 56 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington.

PARENTS
10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Thomas Lord. Mayfield, Idaho.

15. Filed 6-13, 1930 W. F. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12th 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/2, 1930, to 6/12, 1930
that I last saw him alive on 6/12, 1930
and that death occurred, on the date stated above, at 5:10 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
cardiovascular failure

(duration) ..... yrs. ..... mos. 3 hours

CONTRIBUTORY (Secondary) Head injury & communicated multiple fracture jaw
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 6/12
Was there an autopsy?
What test confirmed diagnosis? None
(Signed) [signature], M. D.
6/13/30, 19..... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 6/15/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

colored

DO NOT WRITE IN THIS SPACE
State File No. 70794

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1904
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 177
161a

2. **FULL NAME** Infant Bowen

(a) Residence. No. 511 ½ Main st. St.
(Usual place of abode.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June-9-1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise Idaho,
(State or country)

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)
12. MAIDEN NAME OF MOTHER Edna Bowen
13. BIRTHPLACE OF MOTHER (city or town) Idaho,
(State or County)

14. Informant Edna Bowen
(Address) 511 ½ Main St Boise Idg

15. Filed 6-12, 1930 W. R. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930 to June 9, 1930
that I last saw him alive on June 9, 1930
and that death occurred, on the date stated above, at 9 45 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Birth
(6½ or 7 mo. pregnancy.)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Observation
(Signed) H. C. Beckman, M. D.
June 10, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	June 12 1930
20. Undertaker	Address
Summers & Krebs	Boise Idg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70795

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 476
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Eduard Coder 92

(a) Residence. No. Grandview Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 36 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 17-1863

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	0	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brockport Pa.

PARENTS

10. NAME OF FATHER James R Coder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Not Obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pa.

14. Informant (Address) Mrs Ethel Moore Hermiston Oregon

15. Filed 6-12, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to June 9, 1930, that I last saw him alive on June 8, 1930, and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Cardio Vascular degeneration (duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 5/14/30
Was there an autopsy? yes
What test confirmed diagnosis? Clinical Symp.
(Signed) Fred A. Falkenberg, M. D.
6/12, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal	Date of Burial
Grandview Ida	6-13 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70796

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 175
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME James B. Poteet.
(a) Residence. No. Boise, Idaho Route #5. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Tessie Poteet.

6. DATE OF BIRTH (month, day and year) November 13th1856

7. AGE Years 73 Months 6 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep Raising and
(b) General nature of industry, business, or establishment in which employed (or employer) Farming.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Placerville, Calif;

PARENTS
10. NAME OF FATHER Thomas J. Poteet.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Rebecca Allison.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant (Address) Mrs. Tessie Poteet. ~~Boise, Idaho R#5~~

15. Filed 6-11, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930 to June 7, 1930
that I last saw h..... alive on June 7, 1930
and that death occurred, on the date stated above, at 1:35 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Labor Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical Exam
(Signed) James L. Stewart M. D.
6/9/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 6/12/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20797

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 1744
(No. 1317 State St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clifford Eugene Robison. 1014

(a) Residence. No. 1317 State St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Edith Robison

6. DATE OF BIRTH (month, day and year) June 27th 1878

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	11	10	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Piano Tuner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Deep River, Iowa.

PARENTS

10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Mrs. Edith Robison. Boise, Idaho.

15. Filed 6-10, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 7, 1930
that I last saw him alive on June 7, 1930
and that death occurred, on the date stated above, at 10:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 3/24 ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) O. S. Allen, M. D.
6/9/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	6/10/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70798

PLACE OF DEATH
County of Adams
City of Council

Registration District No. 71
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Charles Artimus Barbour 14

(a) Residence. No. Adams Co. Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nancy May Shaw

6. DATE OF BIRTH (month, day and year) June 5 1859

7. AGE Years 71 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Edward Barbour
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Kirkpatrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Evelyn Kersey
(Address) Midvale Idaho.

15. Filed July 2, 1930 W. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) ~~30~~ 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June ~~30~~ 29, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:
Tick Fever

10 days (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart
(3) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Experience
(Signed) W. M. Brown, M. D.
July 1, 1930 (Address) Starky

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal (?) Date of Burial June 19

20. Undertaker Hudelson Address Cambridge

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JUN 25 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 88

County of Adams

Primary Registration District No.

City of Indian Valley (No. ....., ... St.)

File No. 70799

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James W Harrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. July (Month) 3 (Day) 1860 (Year)

7. AGE 69 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Stock Raiser

(b) General nature of industry, business, or establishment in which employed (or employer)... & Dairy

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER James B Harrell

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Mehala Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X

(Address) Carl Harrell

15.

Filed ..... 191....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1930 (Year) 92

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929, to June 1 1930, that I last saw him alive on June 1 1930, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio-sclerosis.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Lehman M. D.

19..... (Address) Cambridge Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley

DATE OF BURIAL: June 14 1930

20. UNDERTAKER: J A Hadelson

ADDRESS: Cambridge Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70800

Registration District No. 71
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Adams
City of Tamarack, (Woodlawn)

2. FULL NAME Walter Thomas Dailey. 96

(a) Residence. No. (Woodlawn, 1/2 mile from Tamarack) St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Babe.

6. DATE OF BIRTH (month, day and year) June 3, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Tamarack.
(State or country) Adams County, Idaho.

PARENTS

10. NAME OF FATHER Jacob P. Dailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Hazel Willis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Father Jacob P Dailey
(Address)

15. Filed July 15, 1930 W. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10th (10) 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1930 to January 10 1930
that I last saw him alive on January 10, 1930
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Laryngitis, Acute

(duration) — yrs. — mos. few ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? No. Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) W. N. Schuyler, M. D.
January 10, 1930 (Address) New Meadows, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Helmut Cemetery	1-11-1930

20. Undertaker	Address
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70801

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5859

1193

2. FULL NAME Caroline Margrete Strauss

(a) Residence. No. 622 So 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ ~~(or)~~ WIFE of Louis Strauss

6. DATE OF BIRTH (month, day and year) Jan 21st 1889

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	5	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Oppenheimer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Louis Strauss
(Address) 622 So 6th.

15. Filed 7-7, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 5, 1930
that I last saw h~~e~~er alive on July 5, 1930
and that death occurred, on the date stated above, at 6:30 a m.
The CAUSE OF DEATH* was as follows:
Paralytic illeus following Abdominal hysterectomy
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 3rd
Was there an autopsy? No
What test confirmed diagnosis? Histologic
(Signed) Ann Newton, M. D.
July 7, 1930 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt View — Date of Burial: 7-6 1930

20. Undertaker: Schumacher & Beasley — Address: Pocatello

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70802

PLACE OF DEATH
County of Bonnock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Lynn Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5858

1198B

2. FULL NAME Emma Grow
(a) Residence. No. Route #1 Tyhee St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ ~~(or)~~ WIFE of James C Grow

6. DATE OF BIRTH (month, day and year) July 7th 1893

7. AGE Years 36 Months 11 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Gerbrandt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant James C Grow
(Address) Pocatello Idaho

15. Filed 7-7, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 30 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to June 30, 1930
that I last saw her alive on June 30, 1930
and that death occurred, on the date stated above, at 9 35 A m.
The CAUSE OF DEATH* was as follows:
post operative
Ileus
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Chronic gallbladder
adhesions (duration) 4 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 27 30
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) H. L. Lynn M. D.
7-1, 1930 (Address) City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt View — Date of Burial July 1 1930

20. Undertaker Schumacher & Beasley — Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70803

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 23
Primary Registration District No. 2161
Local Registrar's No. 5857

(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Samuel Harper

(a) Residence. No. 319 No. Johnson St. St. Rupert, Idaho, R.F.D. #2
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 4 ds. How long in U. S., if of foreign birth? 64 yrs. 7 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, ~~or divorced~~
HUSBAND of
~~(or) WIFE of~~ Emma Nora Harper

6. DATE OF BIRTH (month, day and year) Sept. 15, 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	10	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London, England.

PARENTS

10. NAME OF FATHER Benjamin Harper

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Elizabeth Phipps

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant J. B. Harper
(Address) Moreland Idaho

15. Filed 7-1, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1930, to , 19
that I last saw h~~im~~ alive on June 24, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D C Ray, M. D.
6-26, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Grove City Cemetery Blackfoot, Ida.	
20. Undertaker E. F. Peck	Address Blackfoot, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70804

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5856

(No. 116 Park Ave. Poca., Ida.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oliver Floyd

90

(a) Residence. No. 116 Park Ave. Pocatello St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 7, 1887.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
43	3	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): St.Charles, Idaho.

PARENTS

10. NAME OF FATHER: Leanord Floyd

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Boston, Mass.

12. MAIDEN NAME OF MOTHER: Emma Foster

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. Emma Dills

(Address) 116 Park Ave. Poca., Ida.

15. Filed 6/27/30/, 19 J. R. Young H.C. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 26, 1930

that I last saw him alive on June 26, 1930

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

acute Dilitation Heart

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency injured valves.

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) J. F. Miller, M. D.

6/27/30, 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Charles, Idaho.

Date of Burial: 6/29/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70805

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2181
(No. Lynn Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5855

90

2. FULL NAME Willis Edward Hayes
(a) Residence. No. Eden Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1st 1920

7. AGE Years 10 Months 3 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER J W Hayes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Barnes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant J. W. Hayes
(Address) Eden Idaho

15. Filed 7-1, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1930, to June 23, 1930
that I last saw him alive on June 23, 1930
and that death occurred, on the date stated above, at 9-30 a.m.
The CAUSE OF DEATH* was as follows:
Mitral Insufficient
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Rheumatism
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Examination
(Signed) [signature], M. D.
6-23-, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Idaho
Date of Burial: 6-24 1930

20. Undertaker: Schumacher & Beasley
Address: Pocatello

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70806

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 20
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5853

2. FULL NAME A. C. Weidenlacher

(a) Residence. No. Pocatello, St. Idaho.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day,
About	54			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: James Hogan
(Address): Pocatello, Idaho.

15. Filed 6/25/30. 19 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1930, to June 21, 1930
that I last saw him alive on June 20, 1930
and that death occurred, on the date stated above, at 8 m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W. W. Brothers, M. D.
6/25/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	6/25/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70807

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2 8
Primary Registration District No. 2 6 1
Local Registrar's No. 5852

(No. 424 North 12th. Ave. Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Alfred Samuel Horrocks

(a) Residence. No. 424 North 12th. Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 20, 1930.

7. AGE

Years	Months	Days	If LESS than 1 day,
0	0	0	12 hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Infant
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Alfred S. Horrocks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake City, Utah.
12. MAIDEN NAME OF MOTHER: Belinda May Heath
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Alfred S. Horrocks
(Address) 424 North 12th Ave. Poca., Ida.

15. Filed 6/21/30. 19__ Registrar: J. R. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 20, 1930
that I last saw him alive on June 20, 1930, 19__
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Atelactasis, Premature birth.

(duration) yrs. mos. 1/2

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) M. F. Howard, M. D.
6/21/30. 19__ (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	6/21/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70808

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 2

Primary Registration District No. 161

Local Registrar's No. 5851

(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

June 2/30
100a

2. FULL NAME Alden Richard Houde

(a) Residence. No. 416 South Ninth Ave. Poca., Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 4, 1920.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
9	10	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: At School

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Alden Houde

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Emma Minshew

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina.

14. Informant: Alden Houde
(Address) 416 South Ninth Ave. Poca., Ida.

15. Filed 6/21/30., 19 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 20, 1930 that I last saw her alive on June 19, 1930 and that death occurred, on the date stated above, at 40 m.

The CAUSE OF DEATH* was as follows: Bronchial pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray M. D.
6/21/30., 19 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.

Date of Burial: 6/22/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70809

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5850

160

2. FULL NAME Donald Wm. Smith
(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 14, 1930.

7. AGE Years 0 Months 0 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER A. G. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Marion, Idaho.
12. MAIDEN NAME OF MOTHER Maud Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant A. G. Smith
(Address) 218 South Johnson St. Poca., Ida.

15. Filed 6/19/30., 19.. R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19, 1930. 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to June 19, 1930
that I last saw him alive on June 19, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Icterus Neonatorum
(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
6/19/30., 19.. (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View Cemetery Pocatello, Idaho. Date of Burial 6/19/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70810

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5849

(No. St. Anthony Hospital Pocatello)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48a

2. FULL NAME Samuel Ward Gustaveson

(a) Residence. No. 162 Taft Ave. Pocatello St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 1, 1911.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	5	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer): At School

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Ernest Gustaveson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Evelyn Ward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Beaver, Utah.

14. Informant: Ernest Gustaveson
(Address) Pocatello, Idaho

15. Filed 6/18/30., 19 J R Young Registrar M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to June 11, 1930

that I last saw him alive on June 30, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis
myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic fever

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) [signature] M. D.

6/18/30., 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.

Date of Burial: 6/19/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

ation should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS EATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-portant. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70811

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5848

(No. Subway Hotel, Pocatello, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4/2

2. FULL NAME John A. Jacobson

(a) Residence. No. Santaquin, Utah. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Selma Johnson

6. DATE OF BIRTH (month, day and year) 1866.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	63	Unknown		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9. BIRTHPLACE (city or town) (State or country) Santaquin, Utah.

PARENTS

10. NAME OF FATHER Nels Jacobson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Gunella Jacobson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Carlos N. Jacobson

(Address) Santaquin, Utah.

15. Filed 6/21/30., 19___ J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19___, to ____, 19___

that I last saw h___ alive on ____, 19___

and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

found dead in vacant subway
Hotel building
Myocarditis

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Arthur W Hall

(Signed) Arthur W Hall Coroner M. D.

6/21/30., 19___ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	6/22/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20812

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5347

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Bro. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME Baby Campbell

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 13, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER C. E. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Mabel Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant C. E. Campbell
(Address) Pocatello, Idaho.

15. Filed 6/14/30. 19 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 14, 1930
that I last saw him alive on June 14, 1930
and that death occurred, on the date stated above, at 2 a m
The CAUSE OF DEATH* was as follows:
Bleed Baby

(duration) — yrs. — mos. 1 d

CONTRIBUTORY (Secondary)
(duration) yrs. mos. d

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) J. W. Lynn, M. D.
6/14/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho. Date of Burial: 6/14/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70813

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5846

49

2. FULL NAME Maria R. Hyde

(a) Residence. No. 415 South Sixth Ave. Poca., Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of Wm. A. Hyde

6. DATE OF BIRTH (month, day and year) September 3, 1864.

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	9	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Henry Reddish
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Eliza Hurst
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Wm. A. Hyde
(Address) Pocatello, Idaho.

15. Filed 6/14/30., 19.... J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jun 13, 1930, to Jun 13, 1930
that I last saw h 49 alive on Jun 13, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Thomas, M. D.
6/14/30., 19.... (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	6/16/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70314

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. .....
Primary Registration District No. 161 Local Registrar's No. 5745
(No. Poc. Gen. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. **FULL NAME** Donald Edward Lewis
(a) Residence. No. 1304, So. 6th ave St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Pocatello, Idaho
7. AGE: Years | Months | Days — lived one hour — If LESS than 1 day, 1 hour hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pocatello Idaho

PARENTS
10. NAME OF FATHER: Edward R. Lewis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): California
12. MAIDEN NAME OF MOTHER: Vemg M. Corahoff
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Idaho

14. Informant (Address): Edward R. Lewis 1304, So 6th ave
15. Filed June 14, 1930, J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 13, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 13, 1930 that I last saw him alive on June 13, 1930 and that death occurred, on the date stated above, at 1:40 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature (7 mo)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Placenta Previa
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W. W. Brothers M.D.
June 14, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho — Date of Burial: June 14 1930
20. Undertaker: McHan Undt Co — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70816

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 2
Primary Registration District No. 216.1
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5843

34

2. FULL NAME John Merideth Evans

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1881.

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	0	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad, Idaho.

PARENTS

10. NAME OF FATHER John Morgan Evans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah.
12. MAIDEN NAME OF MOTHER Isabell Burnett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City, Utah.

14. Informant Mrs. Coffin
(Address) Arimo, Idaho

15. Filed 6/13/30, 19 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to June 10, 1930.
that I last saw him alive on June 10, 1930.
and that death occurred, on the date stated above, at 10.55 P m.
The CAUSE OF DEATH* was as follows:
Cerebrospinal syphilis (Meningitis)
many years (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis - syphilitic
many years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Wassermann on blood and spinal fluid
(Signed) O. W. Hughart, M. D.
6/13/30, 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arimo, Idaho.	6/13/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70817

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5842
(No. General Hospital Pocatello)
(If death occurred in a hospital or institution, give its name instead of street and number.)

149

2. FULL NAME Emely Margaret Wilson
(a) Residence. No. 349 So. Grant St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mr. John B. Wilson

6. DATE OF BIRTH (month, day and year)

7. AGE Years 32 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER J. M. W. Conon
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Mr. John B. Wilson

15. Filed 7-1, 1930 J. R. Young Registrar. H.C.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-8, 1930, to 6-10, 1930
that I last saw her alive on 6-10, 1930
and that death occurred, on the date stated above, at 1 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
puerperal Eclampsia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
6-10, 1930 (Address)

19. Place of Burial, Cremation, or Removal Pocatello Idaho | Date of Burial 19

20. Undertaker H. L. McKan | Address Poca. Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70818

PLACE OF DEATH
County of Bannock
City of Pocatello Ida.

Registration District No. 3
Primary Registration District No. 2161 Local Registrar's No. 5841
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46 B

2. FULL NAME Stephen Douglas Duncan
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. S. L. Duncan

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
70	3	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Henry Duncan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Lewis
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mr. S. L. Duncan,

15. Filed 7-1, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 8, 1930
that I last saw him alive on June 8, 1930
and that death occurred, on the date stated above, at 3 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Mastoiditis
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Senility + Toxemia
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? his home
Did an operation precede death? yes Date of June 7-1930
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) C W Bond M. D.
June 9, 1930 (Address) Kane Bldg Pocatello

19. Place of Burial, Cremation, or Removal: Blackfoot Idaho
Date of Burial: 6/18/30 19

20. Undertaker: H. L. McHan
Address: Poca. Idaho

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70819

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 2

Primary Registration District No. 2161

Local Registrar's No. 5840

(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1886

2. FULL NAME Clyde H. Fisher

(a) Residence. No. 1420 East Clark St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Singal

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) October 23. 1910

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	7	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student Pocatello

(b) General nature of industry, business, or establishment in which employed (or employer): High School

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Milwaukee Wisconsin

PARENTS

10. NAME OF FATHER: Clyde H. Fisher

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Milwaukee Wisconsin

12. MAIDEN NAME OF MOTHER: Jennie Wohlreb

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Suoth Bend Indiana

14. Informant: C. V. McQuearrie
(Address) 1420 East Clark

15. Filed 7-1, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7. 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930 to June 7, 1930 that I last saw him alive on June 7, 1930 and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Basilar Skull fracture
automobile accident on June 1 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) [illegible] M. D.

6-11, 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountian View Cemetery

Date of Burial: June 10 1930

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70820

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs Registration District No. 84
Primary Registration District No. 2161 Local Registrar's No. 188
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

746

2. **FULL NAME** Phoebe E. H. Waddoups

(a) Residence. No. Swan Lake Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas C. Waddoups

6. DATE OF BIRTH (month, day and year) Mar. 27, 1873

7. AGE

Years	Months	Days	If LESS than 1 day,
57	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lewiston Utah

PARENTS

10. NAME OF FATHER: John Bright
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant: Earl Waddoups
(Address): Swan Lake Idaho

15. Filed June 2, 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Or June 17, 1930, to June 19, 1930
that I last saw her alive on June 17, 1930
and that death occurred, on the date stated above, at 2:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Menapause
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination

(Signed) C. E. Ruth M. D.
June 19, 1930 (Address) Lava Hot Springs

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 70821
Registered No. 187

1. PLACE OF DEATH
County of Bannock
City of Lava Hot Springs (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrietta Brower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 6 (Day) 1891 (Year)

7. AGE: 39 Yrs. 1 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clifton Idaho.

10. NAME OF FATHER: Peter Larson

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Minnie Larson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) E. A. Brower Lava Hot Springs

15. Filed June 30-1930 19
Mrs. J. J. Fitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

146

16. DATE OF DEATH: June (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1930 to June 25 1930 that I last saw her alive on June 25 1930 and that death occurred on the date stated above, at 11:20 P M.

The CAUSE OF DEATH* was as follows:
Death Toxemia of Pregnancy
After therapeutic abortion

(Duration) Yrs. 3 mos. ds.
Contributory (Secondary) General toxemia
(Duration) yrs. mos. ds.

(Signed) E. A. Rich M. D.
6-25 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70823

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs

Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 185

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Clarence A. Bristol
(a) Residence. No. Lava Hot Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Deceased

6. DATE OF BIRTH (month, day and year) April 5 - 1851

7. AGE Years 79 Months 2 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich

PARENTS
10. NAME OF FATHER H. D. W. Bristol
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Olive~~ Mich
12. MAIDEN NAME OF MOTHER Olive A Minor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rochester N. Y.

14. Informant G. A. Bristol
(Address) El Centro Calif

15. Filed June 30, 1930. Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to June 8, 1930
that I last saw him alive on June 8, 1930
and that death occurred, on the date stated above, at 9:10 P. m.
The CAUSE OF DEATH* was as follows: Cancer of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X-Ray Diagnosis
(Signed) C. A. Rich, M. D.
6-8, 1930 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Love Cemetery
Date of Burial June 12 1930

20. Undertaker Arthur W Hall
Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70825

PLACE OF DEATH
County of Bannock
City of Lava Hot Springs
Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 183
(No. Lava Idaho Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100A

2. FULL NAME Levie Moneque
(a) Residence. No. Lava Hot Springs Ida. St. Grace Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? no yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of yes.

6. DATE OF BIRTH (month, day and year) not known.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo. Utah.

PARENTS

10. NAME OF FATHER not known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Martha L Hemmert
(Address) Lava Hot Springs Ida.

15. Filed June 30, 1930 Mr G G Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14th (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 14, 1930
that I last saw him alive on May 14, 1930
and that death occurred, on the date stated above, at 5 m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Lava Ida.
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Medical.
(Signed) G G Fitz, M. D.
5-15- 1930 (Address) Bancroft Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grace Ida.	5-15- 1930

20. Undertaker Had none, Mr. Jones Lava Ida. Address Grace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7008 f

Local Registrar's No. 182

PLACE OF DEATH

County of Bannock

City of Bancroft

Registration District No. 84

Primary Registration District No. 2161

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

1600

2. FULL NAME Emma Jane Jacobsen

(a) Residence. No. Bancroft Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Oliver Jacobsen

6 DATE OF BIRTH (month, day and year) Nov 18 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bloomington Ida

PARENTS

10 NAME OF FATHER John B Thornock

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Emma Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Oliver Jacobsen

(Address) Bancroft Ida

15 Filed June 1, 1930 Mrs. G. G. Fritz
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on May 13, 1930,
and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

Systemic infection, General gangrenes
caused from ~~Injury~~ Bite of ~~a~~ Insect a slight injury
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Had a year ago.

..... (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) G G Fritz, M. D.

June 1, 1930 (Address) Bancroft Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation,~~ or Removal	Date of Burial
Bloomington Ida	May 1930
20. Undertaker Had none	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70827

PLACE OF DEATH
County of Bannock
City of Oxford

Registration District No. 8-3
Primary Registration District No. 2160
(No. Oxford, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

144 e

2. FULL NAME James Milton Eriksen

(a) Residence. No. Oxford, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 9, 1927.

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	1	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Child
(c) Name of employer: At Home

9. BIRTHPLACE (city or town) (State or country): Oxford, Idaho.

PARENTS

10. NAME OF FATHER: J. M. Eriksen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Logan, Utah
12. MAIDEN NAME OF MOTHER: Susie Crowshaw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: Mrs. J. M. Erikson
(Address): Oxford, Idaho.

15. Filed ~~6/25/30~~, 19 Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Struck by Automobile
Conducted by Brown
(Accidental)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner, M. D.
6/25/30., 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oxford Cemetery Oxford, Idaho.	6/24/30. 19
20. Undertaker: Hendricks Mortuary	Address: Preston, Ida

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... St.)

2. FULL NAME La Vida Blopham

Board of Vital Statistics
Bureau of Vital Statistics

File No. 70828

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

The information on this certificate is an exact COPY of the official certificate at place of death.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX. Female

4. COLOR OR RACE. White

5. Single, Married, Widowed or Divorced. Child (Write the word.)

6. DATE OF BIRTH. Feb. 26, 1929 (Month) (Day) (Year)

7. AGE. 1 Yrs. 3 Mos. 26 ds. IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION.
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE. (State or Country) Lava Hot Spgs. Ida.

10. NAME OF FATHER Horace R. Blopham

11. BIRTHPLACE OF FATHER (State or Country) Kaysville Ut.

12. MAIDEN NAME OF MOTHER Katleryn Isom

13. BIRTHPLACE OF MOTHER (State or Country) Mountain Dell Ut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Horace R. Blopham
(Address) Downey Ida.

15. Filed July 8, 1930 Mary C. Coffin Local Registrar.

Place Where Remains are to be Sent | Date of Shipment ....., 191...

SHIPPING UNDERTAKER
ADDRESS ..... Firm Name .....

MEDICAL CERTIFICATE OF DEATH.

100a

16. DATE OF DEATH June 22, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21, 1930, to June 22, 1930, that I last saw her alive on June 22, 1930, and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH was as follows:
Broncho Pneumonia.

(Duration) ..... Years ..... mos. 2 ds.

Contributory (Secondary.) Marasmus

(Duration) ..... Years ..... mos. ..... ds.

Signed H. J. Hartigan M. D.

June 23, 1930 (Address) Downey, Idaho

* State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transient or Recent Residents.)

At place ..... in the .....

of death ..... yrs. ..... mos. ..... days State ..... yrs. ..... mos. ..... days

Where was disease contracted

if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida | Date of Burial June 24, 1930

20. UNDERTAKER J. Guy Benson | Address Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECD JUN 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70829

Registration District No. 20
Primary Registration District No. 2161
Local Registrar's No. 5820

PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Dorothea Darlene Mallan 41
(a) Residence. No. Pingree St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 28 1902

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	1	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pawhuska Oklahoma

PARENTS

10. NAME OF FATHER Henry E. Lackey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Springfield Ill.
12. MAIDEN NAME OF MOTHER Rosa Ryan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wellington Kansas

14. Informant Geo A. Reece
(Address) Pingree Idaho

15. Filed 5-15, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/2/30, 19..., to 5/13/30, 19...
that I last saw her alive on 5/13/30, 19...
and that death occurred, on the date stated above, at 10 15 P m.
The CAUSE OF DEATH* was as follows:
General Sepsis following Hysterectomy (5/8/30) -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hysterectomy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Soc. Hosp.
Did an operation precede death? Yes Date of 5/8/30
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) H C [illegible], M. D.
5/14, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
From Lesley Cemetery	May 16 1930
20. Undertaker E J Peck	Address Blackfoot

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

Dr. H.C. Irwin
Pocatello, Idaho
Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

JUL 10 1961

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

ENCLOSED.

Information DESIRED in order to complete certificate:

We cannot make out the name of this woman. Will you please write it more plainly? Also, the birthplace. Both are illegible.

PLEASE ANSWER BELOW:

Mrs Harrison Naillon Pingree Idaho
Died following hysterectomy - General Sepsis
Septicaemia - autopsy did not reveal any
cancer for death in abdomen -
Left Parotid infected (probably streptococci
Pawhuska Oklahoma

6/19/32 H C Irwin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70834

PLACE OF DEATH

County of Bear Lake

City of Montpelier

Registration District No. 52

Primary Registration District No. 2136

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Williams

(a) Residence. No. Montpelier Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13-1849

7. AGE Years 81 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer.

(c) Name of employer (Retired)

9. BIRTHPLACE (city or town) (State or country) Wales.

PARENTS

10. NAME OF FATHER Thomas Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Janette Coyzens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mrs. Jesse Dunn

(Address) Montpelier Idaho

15. Filed 6/30, 1930 N. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 16, 1930,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. H. King, M. D.

May 17, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier

Date of Burial May 20 1930

20. Undertaker T. H. Williams

Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70836

PLACE OF DEATH
County of Bear Lake
City of Dingle

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101 a

2. FULL NAME Ollie G. Hopkins
(a) Residence. No. Dingle Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 - 1851

7. AGE Years 78 Months 11 Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Bush.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known?
12. MAIDEN NAME OF MOTHER Not known?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known?

14. Informant Wesley Dodge
(Address) Dingle Idaho

15. Filed 30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 12, 1930
that I last saw her alive on April 12, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) L. P. Gaertner M. D.
Apr 14, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial Apr 16 1930

20. Undertaker [signature] Address Montpelier Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70837

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 54
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

117

2. FULL NAME Anna Rohner
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 31 1894
7. AGE Years 35 Months 7 Days 14 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Montpelier Idaho

PARENTS
10. NAME OF FATHER John Jacob Rohner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Donathea Ambuehl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Alfred Rohner
(Address) 1125 Allegheny Ave. N.S. Pittsburg Pa.
15. Filed 7/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 14, 1930
that I last saw her alive on April 14, 1930
and that death occurred, on the date stated above, at 3:20 p.m.
The CAUSE OF DEATH* was as follows: Operation (Appendectomy)
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pus Appendicitis
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy? [illegible]
What test confirmed diagnosis?
(Signed) [signature] M. D.
Apr 15, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial April 17 1930
20. Undertaker [signature]
Address Montpelier Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70838

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 436
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

135

2. FULL NAME Franklin R. Bacon
(a) Residence. No. Georgetown Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4 - 1862

7. AGE: 67 Years | Months: 10 | Days: 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pleasant Grove Utah.

PARENTS

10. NAME OF FATHER: Francis Bacon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Jane Soder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: F. W. Bacon
(Address) Georgetown Idaho

15. Filed 6/30/, 1930 F. H. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to April 20, 1930
that I last saw him alive on April 21, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Operations (Prostatic)
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Old age
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of April 1-30
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo F. Tuckey, M. D.
Apr 21, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Georgetown Idaho | Date of Burial: Apr 22 1930

20. Undertaker: F. W. Williams | Address: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70839

PLACE OF DEATH

County of Montpelier Bear Lake

City of Montpelier

Registration District No. 23

Primary Registration District No. 2136

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188e

2. FULL NAME Fredrick Sutter

(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 20 1906

7. AGE Years 23 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montpelier Idaho

PARENTS

10. NAME OF FATHER Rudolph Sutter

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Lena Warren

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Rudolph Sutter
(Address) Montpelier Idaho

15. Filed 6/30/1930 H H King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to April 28, 1930 that I last saw him alive on April 28, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Rupture of Liver

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Auto Mach (Injury)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) G. P. Gaertner, M. D.

Apr 29, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho

Date of Burial May 2 1930

20. Undertaker F. H. Williams

Address Montpelier Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70840

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 3
Primary Registration District No. 2136
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

121

2. FULL NAME Hannah Ansell
(a) Residence. No. Montpelier Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 23 - 1856.

7. AGE Years	Months	Days	If LESS than 1 day,
73	9	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS
10. NAME OF FATHER Joseph Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Wm J. Ansell
(Address) Montpelier Idaho

15. Filed Apr 28, 1930 H H Krieg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to April 25 1930
that I last saw h[illegible] alive on April 25 1930
and that death occurred, on the date stated above, at 4:15 p.m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) 6 mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings
(Signed) H H Krieg, M. D.
Apr 26, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montpelier Idaho	April 28 1930
20. Undertaker	Address
[illegible]	Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70841

PLACE OF DEATH
County of Bear Lake
City of Wardboro

Registration District No. 52
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

10/B

2. FULL NAME Elley M. Keetch
(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas G Keetch
6. DATE OF BIRTH (month, day and year) June-16-1864
7. AGE Years 65 Months 10 Days 14 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) St Charles Idaho

PARENTS
10. NAME OF FATHER Jonathan Puymire
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Caroline Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Chas. P. Keetch
(Address) Montpelier Idaho
15. Filed 30, 1930 W N Fenn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to April 30, 1930
that I last saw her alive on April, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Lee F Kelly, M. D.
April 30, 1931 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wardboro Idaho
Date of Burial May 4 1930
20. Undertaker Ira Williams
Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70842

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

128

2. FULL NAME John C. Stewart
(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16 1865

7. AGE Years 65 Months 1 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Charles Idaho

PARENTS
10. NAME OF FATHER John C. Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alabama.
12. MAIDEN NAME OF MOTHER Mary Jane Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Jersey.

14. Informant Mrs John C. Stewart
(Address) Montpelier Idaho

15. Filed 6/30, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 28, 1930
that I last saw her alive on March 28, 1930
and that death occurred, on the date stated above, at 2 30 p m.
The CAUSE OF DEATH* was as follows:
Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Eric F. Eichler, M. D.
4-1, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wardboro Idaho
Date of Burial Mar 31 1930

20. Undertaker [illegible] Williams
Address Montpelier Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70843

PLACE OF DEATH
County of Bear Lake
City of Bennington

Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Edwin Lindsay
(a) Residence. No. Bennington Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 4 1855

7. AGE Years 74 Months 11 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Edwin R. Lindsay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Tobitha Crayen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Reuben Lindsay
(Address) Bennington, Idaho

15. Filed 1/30, 1930 H. H. Kling Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to Mar 30, 1930
that I last saw him alive on Mar 29, 1930
and that death occurred, on the date stated above, at 39. m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. P. Gardner M. D.
Mar 31, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bennington Idaho
Date of Burial Apr. 2 1930

20. Undertaker H. H. Williams
Address Montpelier Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70845

PLACE OF DEATH
County of Bear Lake
City of Ovid

Registration District No. 22
Primary Registration District No. 2136
Local Registrar's No.

(No.) 131
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Keyia Hedbury
(a) Residence. No. Ovid, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Val Hedbury

6. DATE OF BIRTH (month, day and year): Mar 30 - 1907

7. AGE: Years 22 | Months 11 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sharon Idaho

PARENTS
10. NAME OF FATHER: D. G. Crossley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Liberty Idaho
12. MAIDEN NAME OF MOTHER: Pearl Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): St Charles Idaho

14. Informant: Val Hedbury
(Address) Ovid Idaho

15. Filed 6/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 12, 1930
that I last saw her alive on March 12, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: (uremia)
Coma due to kidney trouble
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Chied Bertha nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
Mar 13, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ovid Idaho | Date of Burial: Mar 16 1930

20. Undertaker: F. H. Williams | Address: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70846

PLACE OF DEATH
County of Bear Lake
City of Dingle

Registration District No. 52
Primary Registration District No. 7136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101 B

2. FULL NAME Delmore Russell Bird
(a) Residence. No. Dingle Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 13 - 1929.

7. AGE Years 1 Months Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Dingle Idaho
(State or country)

PARENTS

10. NAME OF FATHER Roy Bird.
11. BIRTHPLACE OF FATHER (city or town) Dingle Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Natala Hansen
13. BIRTHPLACE OF MOTHER (city or town) Montpelier Idaho
(State or Country)

14. Informant Roy Bird
(Address) Dingle Idaho

15. Filed Sep 30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to March 16, 1930
that I last saw him alive on March 16, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
3-18, 1938 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Dingle Idaho
Date of Burial Mar. 19. 1930

20. Undertaker [signature]
Address Montpelier Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70847

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 54
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

117

2. FULL NAME Lanoz Schmid Ida
(a) Residence. No. Georgetown St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 19 1917
7. AGE Years 12 Months 11 Days 1 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Georgetown Idaho

PARENTS
10. NAME OF FATHER August Schmid
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Julia E Kuny
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bern Idaho

14. Informant August Schmid
(Address) Georgetown Idaho
15. Filed 3/30/1930 N. Nilsen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 18, 1930 to March 20, 1930
that I last saw him alive on March 20, 1930
and that death occurred, on the date stated above, at 2 AM m.
The CAUSE OF DEATH* was as follows:
Pers Appendicitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
3-21, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Idaho
Date of Burial Mar. 23 1930
20. Undertaker F. McWilliam
Address Montpelier Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70848

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

1a

2. FULL NAME W. Radcliffe Hess
(a) Residence. No. Georgetown Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) ~~Not~~ Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 9 - 1910

7. AGE Years 19 Months 11 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown Idaho

PARENTS

10. NAME OF FATHER Wilford W Hess
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgetown Idaho
12. MAIDEN NAME OF MOTHER Lea Nora C Piggott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Georgetown Idaho

14. Informant Wilford W. Hess
(Address) Georgetown Idaho

15. Filed 6/30/1930 H H Kunz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6, 1930, to March 4, 1930
that I last saw here alive on March 4, 1930
and that death occurred, on the date stated above, at 3 20 p m.
The CAUSE OF DEATH* was as follows:
Typhoid fever
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Operation
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 2-10-30
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) Eric F Eichley M. D.
Mar 5, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Date of Burial Mar. 6 1930

20. Undertaker J M Williams Address Montpelier Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70849

PLACE OF DEATH
County of Bear Lake
City of Wardboro

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

181 B

2. FULL NAME Anna R. Gregerson
(a) Residence. No. Montpelier Idaho (Wardboro) St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 4 - 1857
7. AGE Years 72 Months 8 Days 22 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Denmark
PARENTS
10. NAME OF FATHER Jens Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark
14. Informant Mrs Frank Edgwell
(Address) Wardboro Idaho
15. Filed 9/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 9-25, 1930, to 2-26, 1930
that I last saw her alive on Feb 25, 1930
and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Old age
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Geo F Lichley, M. D.
Feb 27, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho Date of Burial Feb 28 1930
20. Undertaker [signature] Address Montpelier Idaho

WRITE PLAINLY, WITH UNFAIRLY ...
N. B.—Every item of information should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly class TION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70850

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 59
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

161B

2. FULL NAME Stanley N. Dalrymple
(a) Residence. No. Montpelier St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 21-1930

7. AGE Years Months Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) Montpelier
(State or country) Idaho

PARENTS
10. NAME OF FATHER Stanley Dalrymple
11. BIRTHPLACE OF FATHER (city or town) Wardboro
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Gwendolyn Pugmire
13. BIRTHPLACE OF MOTHER (city or town) Fish Haven
(State or Country) Idaho

14. Informant Stanley Dalrymple
(Address) Montpelier Idaho

15. Filed 30, 1930 N. N. Revy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb 22, 1930
that I last saw him alive on Feb 22, 1930
and that death occurred, on the date stated above, at 12 noon
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage due to Trauma from forceps
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore, M. D.
Feb 23, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial Feb 23 1930

20. Undertaker [illegible] William
Address Montpelier Idaho

FROM is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70851

PLACE OF DEATH
County of Bear Lake
City of Montpelier Idaho

Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Don C. Smith

(a) Residence. No. Hyrum, Utah St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

77

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 29 - 1901

7. AGE Years 28 Months 4 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work B. B. Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) O.S.L. Railroad
(c) Name of employer O.S.L. Ry.

9. BIRTHPLACE (city or town) (State or country) Hyrum Utah

PARENTS
10. NAME OF FATHER Estle Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyrum Utah
12. MAIDEN NAME OF MOTHER Hilda Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hyrum Utah

14. Informant Mrs Estle Smith
(Address) Hyrum, Utah

15. Filed 6/30 1930 N. Hoag Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 19, 1930
that I last saw her alive on Jan 19 1930
and that death occurred, on the date stated above, at 3 40 A m.
The CAUSE OF DEATH* was as follows:
Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible], M. D.
1-20, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hyrum, Utah Date of Burial Jan 23 - 1930

20. Undertaker [illegible] Address Montpelier Idaho

TION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70852

PLACE OF DEATH
County of Bear Lake
City of Montpelier Idaho

Registration District No. 52
Primary Registration District No. 2136

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Smith Bennett

117

(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19-1908

7. AGE Years 21 Months 3 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS
10. NAME OF FATHER Samuel Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Mary Cole
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Mrs Mary Cole Bennett
(Address) Montpelier Idaho

15. Filed 6/30/, 1930 N. N. King Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 18, 1930
that I last saw him alive on Jan 18, 1930
and that death occurred, on the date stated above, at 3 30 p m.
The CAUSE OF DEATH* was as follows:
Pus Appendicitis
Peritonitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of 1-17-30
Was there an autopsy? [illegible]
What test confirmed diagnosis?
(Signed) [illegible], M. D.
1-20, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho Date of Burial Jan 21 1930

20. Undertaker [illegible] Address Montpelier Idaho

TION is very important. See instruction on back of certificate. Exact statement of OCCUPA-

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70856

PLACE OF DEATH
County of Bear Lake
City of Montpelier Idaho

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

162

2. FULL NAME Ray Ellis Taylor
(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 5-1930

7. AGE Years Months Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Infant

9. BIRTHPLACE (city or town) Montpelier
(State or country) Idaho

PARENTS

10. NAME OF FATHER E. B. Taylor
11. BIRTHPLACE OF FATHER (city or town) Ogden
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Phyllis Lowry
13. BIRTHPLACE OF MOTHER (city or town) Manti
(State or Country) Utah

14. Informant E. B. Taylor
(Address) Montpelier Idaho

15. Filed 30, 1930 N. Kenny Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 7, 1930
that I last saw him alive on Feb 7, 1930
and that death occurred, on the date stated above, at 10.30 a m.
The CAUSE OF DEATH* was as follows:
Asphyxia Pallida
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore M. D.
Feb. 8, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho Date of Burial Feb. 8-1930

20. Undertaker H. W. Allen Address Montpelier

See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70857

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Hilleman M. Nelson
(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Carter

6. DATE OF BIRTH (month, day and year) 1884

7. AGE 45 Years | Months 3 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Newspaper Manager.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER H. P. Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs H. M. Nelson
(Address) Brigham City Utah

15. Filed 6/30, 1930 H. Ashley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Feb 28, 1930
that I last saw him alive on Feb 28, 1930
and that death occurred, on the date stated above, at 29. m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. P. Gaithier M. D.
2-28, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Brigham City Utah | Date of Burial Mar. 4 1930
20. Undertaker F. M. Williams | Address Montpelier Idaho

TION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70858

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Emma C. Bertwistle
(a) Residence. No. Montpelier Ida St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Bertwistle

6. DATE OF BIRTH (month, day and year) Oct 17 - 1900

7. AGE 29 Years | Months 6 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montpelier Idaho

PARENTS
10. NAME OF FATHER Jacob J. Kunz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Emma B. Sutter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Mrs Jacob J. Kunz
(Address) Montpelier, Idaho

15. Filed 6/30, 1930 H. H. Kunz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to May 14, 1930
that I last saw her alive on May 14, 1930
and that death occurred, on the date stated above, at 6:40 A m.
The CAUSE OF DEATH* was as follows:
Acute Pulmonary Tuberculosis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
Pregnancy (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Oregon
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. P. Gaerhier, M. D.
May 15, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho | Date of Burial May 17 1930

20. Undertaker J. McWilliams | Address Montpelier Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70859

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Chas H. Strong 90
(a) Residence. No. Soda Springs Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 26 1850
7. AGE Years 79 Months 9 Days 4 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Massachusetts
PARENTS
10. NAME OF FATHER Henry Strong
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Massachusetts
12. MAIDEN NAME OF MOTHER Not Known?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Massachusetts
14. Informant Leslie Strong
(Address) Soda Springs Idaho
15. Filed 6/1/1930. H H Kerr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to July 1, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:
Organic Heart Trouble
(duration) 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted, if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Ellis Rackley M. D.
July 2, 1930 (Address) by Fr. W. Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Evanston Wyoming — Date of Burial July 3 1930
20. Undertaker H H Williams — Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70860

PLACE OF DEATH

County of Bonner Bur Lake

City of Bonner

Registration District No. 5-V

Primary Registration District No. 2136

Local Registrar's No. 1015

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary C. Westbrook

(a) Residence. No. Mostpleasant St. Norman Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Robt Westbrook

6. DATE OF BIRTH (month, day and year): June 2 - 1930

7. AGE: Years 61 | Months 3 | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Switzerland.

PARENTS

10. NAME OF FATHER: John Gruning

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland.

12. MAIDEN NAME OF MOTHER: Marie Bonne

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland.

14. Informant: Robt Westbrook

(Address): Bonner, Idaho

15. Filed 6/30/, 1930 W. H. Kerr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 1, 1930, that I last saw he alive on June 1, 1930, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Unconscious

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. E. Goldsby, M. D.

June 3, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonner Idaho — Date of Burial: June 4 1930

20. Undertaker: F. M. Williams — Address: Sandpoint Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70861

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

89

2. FULL NAME Lewis Charles Housley
(a) Residence. No. Montpelier Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bell Skinner
6. DATE OF BIRTH (month, day and year) Jan. 25. 1887
7. AGE Years 43 Months 4 Days 22 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) Paradise
(State or country) Utah.

PARENTS
10. NAME OF FATHER Lewis Housley
11. BIRTHPLACE OF FATHER (city or town) Draper
(State or Country) Utah.
12. MAIDEN NAME OF MOTHER Mary E Singelton
13. BIRTHPLACE OF MOTHER (city or town) Plain City
(State or Country) Utah

14. Informant Mrs Lewis Housley
(Address) Montpelier Idaho
15. Filed 6/30/1930 N N Kerry, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 16, 1930
that I last saw him alive on June 16, 1930
and that death occurred, on the date stated above, at 4 m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
not known (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) .....
..... (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J. P. Galshier, M. D.
June 17, 1930 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial June 19 1930
20. Undertaker [illegible]
Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

County of Bear Lake

City of Montpelier

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 52

Primary Registration District No. 2736

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70862

Local Registrar's No.

14a

2. FULL NAME May Lee Jones

(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin Jones

6. DATE OF BIRTH (month, day and year) May 21-1870

7. AGE Years 59 Months 11 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tooele Utah

PARENTS

10. NAME OF FATHER Wm H Lee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Lavern Bates

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Frank Jones

(Address) Montpelier Idaho

15. Filed 6/30/1930 H H Kerr Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24, 1930, to May 8, 1930

that I last saw her alive on May 8, 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy - 12 days

Chronic Parenchymatous Nephritis

Chronic Bronchitis - duration 10 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C O Moore, M. D.

5/9, 1930 (Address) Paris Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho

Date of Burial May 12 1930

20. Undertaker [illegible]

Address Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70863

PLACE OF DEATH
County of Bear Lake
City of Liberty
Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

2. FULL NAME Ca Elizabeth Catherine Clark

(a) Residence. No. Liberty Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Widowed.

5a. If married, widowed or divorced HUSBAND of (or) WIFE of: James Clark

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 71 | Months 6 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Caseyville Ill

PARENTS

10. NAME OF FATHER: William Thymas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Rayleigh England
12. MAIDEN NAME OF MOTHER: Mary Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Carmarthenshire Wales

14. Informant: Samuel E Thymas
(Address) Sharon Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see her, 19 , to , 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at alive m.

The CAUSE OF DEATH* was as follows:
Unknown
Fracture hip Broken shoulder
Right sided hemiplegia
before death (duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterial Hypertension
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No History.
What test confirmed diagnosis?
(Signed) Spencer Finch M.D.
June 30, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Liberty Idaho — Date of Burial: June 30 1930

20. Undertaker: T. L. Austin — Address: Liberty Ida

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70864

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 151

131

2. FULL NAME Lotwick Reese

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane Johns

6. DATE OF BIRTH (month, day and year) Mar 1, 1845

7. AGE Years 85 Months 3 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Glamorgan
(State or country) Wales

PARENTS
10. NAME OF FATHER Thomas Reese
11. BIRTHPLACE OF FATHER (city or town) Wales
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret Jones
13. BIRTHPLACE OF MOTHER (city or town) Wales
(State or Country)

14. Informant Mrs L Reese
(Address)

15. Filed 6-15, 1930 Mrs J. S. Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 11, 1930
that I last saw him alive on June 11, 1930
and that death occurred, on the date stated above, at 6:00 a m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Prostatic Hypertrophy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Enlarged Prostate
albuminuria Uremia Uremic Death
(Signed) Spencer H. Dick M. D.
June 13, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bloomington Ida Date of Burial June 15 1930

20. Undertaker None Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70865

PLACE OF DEATH
County of Bear Lake
City of Fish Haven

Registration District No. 55
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura L. Nelson

(a) Residence. No. Fish Haven Ida St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: John Lyman Nelson

6. DATE OF BIRTH (month, day and year): Aug 2 1874

7. AGE — Years: 55 — Months: 9 — Days: 4 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Richard Bee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Georganna McKetheney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: X D L Nelson
(Address): Fish Haven Idaho

15. Filed , 19 . Hannah Nielson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 6, 1930
that I last saw her alive on May 2, 1930
and that death occurred, on the date stated above, at 1.45a.m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) C O Mann M. D.
5/6/30, 19 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fish Haven Id. — Date of Burial 19

20. Undertaker: C. C. Shirley. — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70866

Registration District No. 55
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Bear Lake
City of St Charles
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 25 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1/2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER William H Loyd
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Clarrie Mattern
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant O O Mecham
(Address) Paris Idaho

15. Filed , 19 . Hannah J Nelson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1930 to May 25, 1930
that I last saw him alive on May 25, 1930
and that death occurred, on the date stated above, at 6.30 P m.
The CAUSE OF DEATH* was as follows:
Premature Birth.
About six months
Cause Unknown
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds. —

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) O O Mecham, M. D.
5/26, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70867

PLACE OF DEATH

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 22

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

4

2. FULL NAME Harold Z Anderson

(a) Residence. No. Parkers Addition St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 2 | Months 1 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) St Maries (State or country) Ida

PARENTS

10. NAME OF FATHER Harvey Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Emma M Gillman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Harvey Anderson

(Address) St Maries

15. Filed 6-7, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 5, 1930

that I last saw him alive on June 4, 1930

and that death occurred, on the date stated above, at 2:15 a m.

The CAUSE OF DEATH* was as follows:

Scarlet fever

..... (duration) ..... yrs. ..... mos. 1 wk ds.

CONTRIBUTORY (Secondary) Arthritis, acute, multiple (duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C A Robins M. D.

6/6, 1930 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida

Date of Burial: June 5 1930

20. Undertaker: Geo E Mitchell

Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70868

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Edward Brigham

(a) Residence. No. ..... St. Emo Ontario Canada
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 26 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Rudgeley Lumber Co Camp No 21

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER: James Brigham
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Albert Holtz
(Address) Clarkia Ida

15. Filed 6-6, 1930 Walter Roberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: accidental, hit by falling limb.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. G. Espe - Coroner, M. D.
6/7/30 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emo, Ontario Can
Date of Burial: 19

20. Undertaker: Geo. E. Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70869

PLACE OF DEATH

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clark

(a) Residence. No. St Maries St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

129

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Unknown				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Common Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Geo E. Mitchell
(Address)

15. Filed June 5, 1930 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 4, 1930
that I last saw him alive on June 4, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous
Nephritis
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C A Robins, M. D.
6/5 1930 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries Ida	June 5 1930
20. Undertaker	**Address**
Geo E Mitchell	St Maries

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70870

PLACE OF DEATH
County of Benewah
City of St. Maries
Registration District No. 32
Primary Registration District No. 2049
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 19

1010

2. FULL NAME Mr. Stephen Coovick

(a) Residence. No. Us 215 Trent avenue, Spokane St. Washington
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a. If married, widowed, or divoreed
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rutledge Timber Company

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Dr. L. A. Robins
(Address) St. Maries, Ida

15. Filed 5-20, 1930 Walter Boking Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-16, 1930, to 5-18, 1930
that I last saw him alive on 5-17, 1930
and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar
(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? In logging camp.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical signs
(Signed) Carolina, M. D.
5-19, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane Wn	
20. Undertaker Geo E. Mitchell	Address St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-18. RECEIVED JUL 7 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bennewah.

City of Plummer. Ida R 2#

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46

Primary Registration District No. 2123.

(No. ..... , ... St.)

File No. 70871

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gay Lee Carrol Grant. 101B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: June (Month) 6th (Day) 1929 (Year)

7. AGE: ..... Yrs. 8 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Plummer. Idaho. R 2#

10. NAME OF FATHER: Chas. A. Grant.

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Danielson

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A. Grant

(Address) Plummer. Ida R 2#

15. Filed Feb. 13 1930

H. E. Jaeger
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 11th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor was called. Parents did not think Child seriously sick. 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Father-thinks Pneumonia.

..... (Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Wrote this History

(Signed) J. J. Herrington M. D.

..... 19..... (Address) Hooley. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer Ida

DATE OF BURIAL: Feb 14 1930

20. UNDERTAKER: H. E. Jaeger

ADDRESS: Plummer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70872

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 9
Township ..... or Village Dr Smet or
City RECEIVED JUL 3 1930 No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mildred Gaze

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

112

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Oct 25-29

7 AGE Years | Months 7 | Days 9 | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Tunnel Idaho
(State or country)

PARENTS

10 NAME OF FATHER Albert Gaze

11 BIRTHPLACE OF FATHER (city or town) Canada
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Vincent

13 BIRTHPLACE OF MOTHER (city or town) Dr Smet
(State or country) Idaho

14 Informant Albert Gaze
(Address) Tensea, Idaho

15 Filed June 4, 1930 John Post
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to June 4, 1930, that I last saw her alive on June 3, 1930, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
(Address) Tes Coa Wa

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Dr Smet, Idaho

DATE OF BURIAL: June 5 1930

20 UNDERTAKER: C. L. Schuberud

ADDRESS: Tekoa Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—209 d
V. S. No. 98

RECEIVED OCT 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70872

1 PLACE OF DEATH
County Benewah State Ida. Registered No.
Township ____ or Village De Smet or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hildred Gaze

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	Indian	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25, '29

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Tensod, Ida.
(State or country)

PARENTS

10 NAME OF FATHER Albert Gaze

11 BIRTHPLACE OF FATHER (city or town) Canada
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Vincent

13 BIRTHPLACE OF MOTHER (city or town) Tensed
(State or country) Ida.

14 Informant
(Address)

15 Filed ____, 19 ____ REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1930

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to June 4, 1930,
that I last saw her alive on June 3, 1930,
and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:
Gastro-Enebritis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
6/9, 1930 (Address) Tekoa, Wn.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
De Smet, Ida.	
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

7087 23

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 12
Township RECEIVED JUL 3 1930 or Village De Smet or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Marie Madelaine Michel

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis Michel

6 DATE OF BIRTH (month, day, and year) Aug 18-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	50	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d Alene
(State or country) Reservation

PARENTS

10 NAME OF FATHER Louis Chistans
11 BIRTHPLACE OF FATHER (city or town) Coeur d Alene
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Martha Tobaston
13 BIRTHPLACE OF MOTHER (city or town) Coeur d Alene
(State or country) Reservation

14 Informant John Post
(Address) De Smet, Idaho

15 Filed June 22, 1930 John Post REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1930, to June 20, 1930, that I last saw her alive on June 20, 1930, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatism

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
(Address) 6/30 De Smet, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
De Smet, Ida	June 23, 1930
20 UNDERTAKER	**ADDRESS**
C. L. Schuderer	Tekoa, Wash.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70874

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 11
Township RECEIVED JUL 3 1930 or Village Dr Smet or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Luke Cheslegu 480

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M
4 COLOR OR RACE Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philesty

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
84	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Reservation

PARENTS
10 NAME OF FATHER Isadore
11 BIRTHPLACE OF FATHER (city or town) Coeur d'Alene
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Sister John Post
(Address) DeSmet, Idaho

15 Filed June 15, 1930 John Post
REGISTRAR

11—3182

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1930

17 I HEREBY CERTIFY, that I attended deceased from May 1, 1930, to June 15, 1930, that I last saw him alive on June 8, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:
Endocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. A. Nelson, M. D.
6/15-30 (Address) Tekoa

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DeSmet, Ida
DATE OF BURIAL June 16 1930

20 UNDERTAKER C. L. Schuler
ADDRESS Tekoa, Wash.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

70875

1 PLACE OF DEATH
County Bluewater State Idaho Registered No. 70
Township RECEIVED JUL 3 1930 or Village Dr Smith or
City ..... No. ....., ... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Irene Anastasia

(a) Residence. No. ..... St., ... Ward. ✓ 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 28, 1916

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
14	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene
(State or country) Reservation Idaho

PARENTS
10 NAME OF FATHER Peter Anastasia
11 BIRTHPLACE OF FATHER (city or town) Idaho
(State or country)
12 MAIDEN NAME OF MOTHER Madeline Anastasia
13 BIRTHPLACE OF MOTHER (city or town) Spokane
(State or country) Reservation

14 Informant Peter Frank
(Address) De Smet, Idaho

15 Filed June 9, 1930 John Post
REGISTRAR

11—2184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to June 9, 1930
that I last saw her alive on June 6, 1930
and that death occurred, on the date stated above, at 5 a.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J. A. Nelson, M. D.
6/9/1930 (Address) Tekoa Wn

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Dr Smith Idaho
DATE OF BURIAL: Jun 10 1930

20 UNDERTAKER: C. L. Schulerud
ADDRESS: Tekoa, Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED OCT 16 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

90875

1 PLACE OF DEATH
County Benewah State Ida. Registered No.
Township ____ or Village DeSmet or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Irene Anasta

(a) Residence. No. ____ St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	14			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d' Alene Reservation
(State or country)

PARENTS
10 NAME OF FATHER Peter Anasta
11 BIRTHPLACE OF FATHER (city or town) Coeur d'Alene
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Madelin Anasta
13 BIRTHPLACE OF MOTHER (city or town) Spokane
(State or country) Reservation

14 Informant Peter Tunk
(Address)

15 Filed ____, 19 ____
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to June 9, 1930, that I last saw her alive on June 6, 1930 and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(SECONDARY)
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
(Address) Tekoa, Wash. 6/9, 1930

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
De Smet, Ida.	June 10 1930
20 UNDERTAKER	ADDRESS

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70877

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

43

2. FULL NAME Corneilius Tiahrt

(a) Residence. No. ..... St. Aberdeen Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. – mos. – ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Anna Tiahrt

6. DATE OF BIRTH (month, day and year) Mar 16th 1856

7. AGE: 74 Years; Months: 2; Days: 26; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer. (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: Siebert Tiahrt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Sara Franz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Otto G Risser
(Address) Aberdeen Idaho

15. Filed June 14, 1930 M C MacKinnon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 12, 1930
that I last saw him alive on June 11, 1930
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma – Epithelioma of lip
(duration) 3 yrs. – mos. – ds.
CONTRIBUTORY (Secondary) Metastatic Carcinoma of lungs (duration) ..... yrs. 1 mos. – ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) M. C. MacKinnon, M. D.
June 14, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen Idaho
Date of Burial: June 15 1930

20. Undertaker: A W Davis
Address: American Falls Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70878

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 6

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Claire Irvin Wahlan

(a) Residence. No. Aberdeen, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 30, 1930

7. AGE Years | Months | Days 11 - | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aberdeen, Ida.

PARENTS

10. NAME OF FATHER Clarence Wahlan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Murray, Utah

12. MAIDEN NAME OF MOTHER Laura Ferguson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spanish Fork, Utah

14. Informant Clarence Wahlan
(Address) Aberdeen Idaho

15. Filed 6-9, 1930 McMarkinson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5:25 a. m.
The CAUSE OF DEATH* was as follows:
Premature labor
28th wk, Cause unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) ....., M. D.
6/9, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen, Ida. | Date of Burial: 6/10 1930

20. Undertaker: Friends | Address: Aberdeen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JUL 7 1930

PLACE OF DEATH

County of Ft. Hall Reservation Idaho.

City of

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70879

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 94

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

149

2. FULL NAME Maud Dan Teton

(a) Residence. No. --- St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Teton

6. DATE OF BIRTH (month, day and year) -- 1902 ---

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	---	---	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nevada

PARENTS

10. NAME OF FATHER Indian Dan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Mattie Preacher

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nevada

14. Informant Henry Teton
(Address) Blackfoot, Idaho.

15. Filed July 1, 1930 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 31, 1930 19
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:

Postpartum Hemorrhage

2 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ft. Hall Reservation, Lincoln Creek Cemetery, Date of Burial Apr. 3 19

20. Undertaker Modern Mortuary, Address Blackfoot, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

Mar. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70882

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho

City of

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 91

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME John L. Sheepskin

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6. DATE OF BIRTH (month, day and year) 1907

7. AGE: Years 23 | Months --- | Days --- | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Bede Sheepskin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Ellen Tinno

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Norman Tinno
(Address) Ft. Hall, Idaho

15. Filed July 1, 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23, 1930, to Mar 24, 19
that I last saw him alive on Mar. 23, 1930, 19
and that death occurred, on the date stated above, at 8: A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

15 Days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ---
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) Henry R. Wheeler, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Butte Cemetery Ft. Hall Reservation, 2-27-30 | Date of Burial 19

20. Undertaker: Brown & Eldredge, Blackfoot, Idaho | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

Mar. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70883

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Idaho
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 90
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac Mosho

82

(a) Residence. No. ---- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ------

6. DATE OF BIRTH (month, day and year) Dec. 20, 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	2	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10. NAME OF FATHER Walter Mosho
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation
12. MAIDEN NAME OF MOTHER Nannie Pocatello
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ft. Hall Reservation

14. Informant Walter Mosho
(Address)

15. Filed July 1, 1930 Walter E. Peterson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8, 1930, to Mar 18, 1930
that I last saw him alive on Mar 18, 1930
and that death occurred, on the date stated above, at 4:A m.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

10 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Mary R. Wheeler M. D.
, 19 (Address) Ft. Hall Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bannock Creek Cemetery Ft. Hall Reservation, 3-21-30 | Date of Burial 19

20. Undertaker: Walter Mosho, Pauline | Address: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current Complete Mar. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70884

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho
Registration District No. 12
City of
Primary Registration District No. 2794
Local Registrar's No. 89
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11a

2. FULL NAME Ahsinek

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Bannock Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	---	--	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Tom Jake
(Address) Ft. Hall, Idaho.

15. Filed July 1, 1930 Mrs Hattie E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 17, 1930
No Doctor Attending (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8:30 p m.
The CAUSE OF DEATH* was as follows:

Flu.

7 Days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia-bronchial

5 days
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Emery R. Wheeler, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery Ft. Hall Reservation,	3-20-30 19

20. Undertaker Agency Carpenter, Ft Hall, Ida
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete Mar. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70885

PLACE OF DEATH

County of Ft. Hall Reservation
City of Idaho.
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 88

(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Neavika

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Pompy Jack

6. DATE OF BIRTH (month, day and year) --- 1838

7. AGE	Years	Months	Days	If LESS than 1 day,
	92	--	--	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Sig-a-bonne
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Alex Watson,
(Address) Blackfoot, Idaho.

15. Filed July 1, 1930 Mrs Walter C. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 8. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 19 29, to Mar.8, 19
that I last saw her alive on Mar. 7. 1930, 19
and that death occurred, on the date stated above, at I: A m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 4 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Henry C. Wheeler, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Mission Ft. Hall Reservation, Ida.	II- 30 19

20. Undertaker Brown & Eldredge, Address Blackfoot, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current Complete

Feb. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70886

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho.
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 87
(No. Ft. Hall Agency Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. FULL NAME Lawrence LaVatta

(a) Residence. No. ---- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 3/16	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6. DATE OF BIRTH (month, day and year) Feb. 20. 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	--	--	1/4 day	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Hospital
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall, Idaho.

PARENTS

10. NAME OF FATHER Thomas LaVatta, Jr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall, Idaho.
12. MAIDEN NAME OF MOTHER Tresa Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyo.

14. Informant Thomas LaVatta.
(Address) Ft. Hall, Idaho

15. Filed July 1, 1930 Mrs Walter E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to Feb. 21, 1930,
that I last saw him alive on Feb. 21. 1930,
and that death occurred, on the date stated above, at 5: A. m.
The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) , M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Episcopal Mission. Ft. Hall. Idaho. 2-	23-30 19

20. Undertaker Agency Carpenter. Ft. Hall. Ida
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

Feb. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70887

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho
Registration District No. 121
City of
Primary Registration District No. 2194
Local Registrar's No. 86
(No. 11a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Longham

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susie Yuve

6. DATE OF BIRTH (month, day and year) ---- 1874

7. AGE	Years	Months	Days	If LESS than 1 day,
	56	--	--	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ruby Valley. Nevada

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Susie Yuve
(Address) Ft. Hall, Idaho

15. Filed July 1, 1930 Mrs Walter E. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 14. 1930 (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1: P m.
The CAUSE OF DEATH* was as follows:

Flu

(duration) 4 days yrs. mos. ds.
CONTRIBUTORY (Secondary) Broncho pneumonia
(duration) 3 days yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Birch Creek Cemetery Ft. Hall Reservation	2-17-30 19

20. Undertaker Agency Carpenter. Ft. Hall Address Reservation

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Feb 1930

DO NOT WRITE IN THIS SPACE
State File No. 70888

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 85
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Victoria Watson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 172	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Watson

6. DATE OF BIRTH (month, day and year) --- 1894

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise. Idaho.

PARENTS

10. NAME OF FATHER George Hoey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise. Idaho.
12. MAIDEN NAME OF MOTHER Segoyou Meeks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Boise. Idaho.

14. Informant Josephine Thorne
(Address) Blackfoot. Idaho.

15. Filed July 1, 1930 Mrs Walter E. Paine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 12. 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11. 1930, 19 to Feb. 12, 1930, 19
that I last saw her alive on Feb. 12. 1930, 19
and that death occurred, on the date stated above, at 5:30P m.
The CAUSE OF DEATH* was as follows:

Nephritis-chronic.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Odema of glottis 1 day

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Henry R. Wheeler, M. D.
, 19 (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Mission Ft. Hall Reservation, 2-	15 30 19
20. Undertaker	Address
Brown & Eldredge.	Blackfoot. Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current Complete

Feb. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70889

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho
Registration District No. 121
City of
Primary Registration District No. 2194
Local Registrar's No. 84
(No. 31)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack Smiler

(a) Residence. No. --- St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Tahrah Broncho

6. DATE OF BIRTH (month, day and year) 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nevada

PARENTS

10. NAME OF FATHER Waddhahaup
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming
12. MAIDEN NAME OF MOTHER Hay-wan-das
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Raft River. Idaho

14. Informant Susie Yupe
(Address) Ft. Hall, Idaho

15. Filed July 1, 1930 Mrs Walter E. Valre
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 9, 1930
(Month) (Day) (Year)
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) I yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Tony R. Wheeler M. D.
..., 19... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bannock Cemetery Ft. Hall Reservation. 2-	13-30 19

20. Undertaker Mc. Han. Pocatello. Idaho Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Current Complete

Feb. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70890

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho. Registration District No. 121

City of ..... Primary Registration District No. 2194

Local Registrar's No. 83

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Narsharre

(a) Residence. No. ---- St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Shoshone Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Boise. Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Unknown

14. Informant Peter Jim
(Address) Blackfoot, Idaho.

15. Filed July 1, 1930 Mrs Wallace E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 7. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1929 to Feb. 7, 19....
that I last saw her alive on Feb. 5. 1930, 19....
and that death occurred, on the date stated above, at 9:P. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the glands of throat

(duration) 7-1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Flu. 5 Days

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Mary E. Mueller M. D.

....., 19.... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Cemetery Ft. Hall. Idaho.	2 10 30 19

20. Undertaker Brown Eldredge, Blackfoot, Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Current Complete Feb 1930

RECEIVED JUL 7 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70891

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Idaho — Ft. Hall Reservation
City of
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 82
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Toomuzzo

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Burton

6. DATE OF BIRTH (month, day and year): --- 1861

7. AGE: Years 69 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Wm. Toomuzzo

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Cankagee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: William Burton
(Address): Ft. Hall, Idaho.

15. Filed July 1, 1930 — Wm. Walter E. Peters, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Feb. 7, 19..., that I last saw him alive on Feb. 7. 1930, 19..., and that death occurred, on the date stated above, at 8:30A m.

The CAUSE OF DEATH* was as follows:

Flu.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY* -----
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? --
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Henry A. Wheeler, M. D.
(Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Portneuf Cemetery Ft. Hall Reservation.	2-12-30 19

20. Undertaker: Agency Carpenter. Ft. Hall, Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Feb. 1930.

Current Complete

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70892

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Idaho.

City of

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 81

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Susan Johnson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Bannock Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of --

6. DATE OF BIRTH (month, day and year) -- 1911

7. AGE: Years 19 | Months -- | Days -- | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ft. Hall Reservation

PARENTS

10. NAME OF FATHER: Tail Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER: Tomoyo

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft. Hall Reservation

14. Informant: Naoma Johnson.
(Address) Ft. Hall, Idaho.

15. Filed July 1, 1930 Wm Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 3, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1926, 19, to Feb. 3, 1930, 19
that I last saw her alive on Feb. 3, 1930, 19
and that death occurred, on the date stated above, at 3: P. m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) 3 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Tuberculosis throat

(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) Henry R. Wheeler, M. D.

, 19 (Address) Ft. Hall, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Butte Cemetery Ft. Hall Reservation. Date of Burial: 2-6-30 19

20. Undertaker: Brown Eldredge? Blackfoot. Address: Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete Feb. 1930

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70893

County of Ft. Hall Reservation, Idaho. Registration District No. 121

City of ..... Primary Registration District No. 2194 Local Registrar's No. 80

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

66

2. FULL NAME Frank Willett.

(a) Residence. No. ..... St. * .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ivy Dover

6. DATE OF BIRTH (month, day and year) 1886.

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	---	---	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Ben Willett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise, Idaho.

12. MAIDEN NAME OF MOTHER Yah-gwat-sah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Eva Nevhi
(Address) Ft. Hall, Idaho.

15. Filed July 1, 1930 Mrs Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 2, 1930
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

1/4 day
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Exposure to cold

I/4 Day
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None Investigated by Coroner

(Signed) Henry W. Wheeler M.D.

-- ....., 19... (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Presbyterian Cem Ft. Hall Reservation,	2-10-30 19
20. Undertaker	Address
Brown-Eldredge,	Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70894

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 79

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16a

2. FULL NAME Joseph Leon Hampton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or 50 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley Ida

PARENTS
10. NAME OF FATHER Harold F Hampton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelley Idaho
12. MAIDEN NAME OF MOTHER Ida Fielding
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Shelley Ida

14. Informant Mrs Joseph Fielding
(Address)

15. Filed June 26, 1930 Shelley Ida
Registrar
Wm Walter E. Patrick

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 24, 1930
that I last saw her alive on June 24, 1930
and that death occurred, on the date stated above, at 1:45 am
The CAUSE OF DEATH* was as follows:
Premature Birth
..... (duration) ..... yrs. ..... mos. ✓ ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) Flat Roberts, M. D.
June 24, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Taylor Cemetery
Date of Burial: June 24 1930

20. Undertaker: Harold F. Hampton
Address: Shelley Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70895

Local Registrar's No. 78

129

PLACE OF DEATH

County of Bingham

City of Shelley

Registration District No. 121

Primary Registration District No. 2144

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Antone Erastus Christensen

(a) Residence. No. Shelley, Idaho St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna C. Christensen

6. DATE OF BIRTH (month, day and year) July 24, 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) San Pete Utah

PARENTS

10. NAME OF FATHER Christen Antone

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Mattie Marie Martinsen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs. A. E. Christensen

(Address) Shelley Idaho

15. Filed June 22, 1930 Mrs. Walter E. Pettis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-12-, 1930, to 6-18-, 1930 that I last saw him alive on 6-18-, 1930 and that death occurred, on the date stated above, at 4 P. M. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis + Prostatectomy

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical -

(Signed) Edwin Cutler, M. D.

6-19-, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shelley Idaho — Date of Burial June 22 1930

20. Undertaker Jack G. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70896

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 77

2. FULL NAME John Ruben Winterbottom 71 B

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 9 1930

7. AGE Years | Months 6 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER Thos H Winterbottom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montpelier Idaho
12. MAIDEN NAME OF MOTHER Ivy Parke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Albion Idaho

14. Informant Thomas H. Winterbottom
(Address) Blackfoot, Idaho

15. Filed June 18, 1930. Walter E. Patrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 18, 1930
that I last saw him alive on June 17, 1930
and that death occurred, on the date stated above, at 5:00 a m.
The CAUSE OF DEATH* was as follows:
Meningitis - non contagious
(duration) — yrs. — mos. 4 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) — yrs. — mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
6/18, 1930 (Address) W W Beck

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth Idaho | Date of Burial: June 19 1930

20. Undertaker: E J Peck | Address: Blackfoot

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70897

PLACE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2144
Local Registrar's No. 76

(No.) 144 C
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard Charles Hall

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3 1914

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lima Mont

PARENTS

10. NAME OF FATHER Howard Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jane Lew West Virginia
12. MAIDEN NAME OF MOTHER Emma Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fort Bridger Wyo

14. Informant Mrs Howard Hall
(Address) 555 W Judicial St, Blackfoot, Ida

15. Filed June 16, 1930 Wm. Milton E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
6-17, 1930, to , 19
that I last saw him alive on 6-17, 1930
and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:
Internal injuries & chest & skull fracture from auto accident
(duration) 3 hrs. yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) J. O. Hathaway M. D.
6-18, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Pocatello Idaho	
20. Undertaker E J Funk	Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70898

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2144
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 75

101a

2. FULL NAME Bert D. Wheeler
(a) Residence. No. Moreland, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14th 1930

7. AGE Years | Months 1 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Moreland Idaho

PARENTS

10. NAME OF FATHER: Roy Wheeler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mapleton Idaho
12. MAIDEN NAME OF MOTHER: Estella Grimmett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Moreland Idaho

14. Informant: Mae Grimmett
(Address) Moreland Idaho

15. Filed June 15, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1930 to June 15, 1930
that I last saw him alive on June 15, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Lobular Pneumonia
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of June 15/30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F. W. Mitchell M. D.
June 15, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Moreland Idaho | Date of Burial: June 16 1930

20. Undertaker: E. F. Fink | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70900

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 73

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Henrietta L. Parson

(a) Residence. No. Blackfoot, Idaho R.F.D.#2 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert N. Parson

6. DATE OF BIRTH (month, day and year): July 31, 1854

7. AGE: Years 75, Months 10, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS

10. NAME OF FATHER: T. Rodgers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Martha Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): .....

14. Informant: Mrs Hans Christensen
(Address) Blackfoot Idaho R#2

15. Filed June 9, 1930 Mrs Walter E. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) – 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6 – 1, 1930, to 6 – 7, 1930
that I last saw her alive on 6 – 7, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical Findings
(Signed) J. O. Hampton, M. D.
6-9- 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem. Date of Burial: 19

20. Undertaker: E. T. Peck Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70901

PLACE OF DEATH

County of BINGHAM

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 72

(No. South Idaho Insane Asylum)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME B. Nagle

(a) Residence. No. ..... St. Franklin County
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year)

7. AGE: 69 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: ---

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown ---

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Grace A Clippinger, R.N.
(Address) Blackfoot, Ida.

15. Filed June 6, 1930 Mrs Walter E Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May June 5th, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd, 1930 to June 5th 1930, 19
that I last saw him alive on June 5th, 1930, 19
and that death occurred, on the date stated above, at 7:30p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
upl. long
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~None~~ Phys Diagnosis

(Signed) W. E. Patrie M. D.

6-6, 1930 (Address) Blackfoot, Id

Temp. acting Asylum Supt.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cemetrary

Date of Burial: 6/6/30 19

20. Undertaker: Edwin Seding

Address: Blackfoot

RECEIVED JUL 7 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70902

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 71

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christena A. Kirwan

(a) Residence. No. Blackfoot R. F. D. #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: E.T. Kirwan

6. DATE OF BIRTH (month, day and year): April 4, 1870

7. AGE: Years 60 | Months 2 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Spanish Fork Utah

PARENTS

10. NAME OF FATHER: Joseph G. Boyack
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Jessi Archbald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: E. T. Kirwan
(Address) Blackfoot R. F. D. #2

15. Filed June 5, 1930 Mrs Walter E Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930 to June 4, 1930
that I last saw her alive on June 4, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
apoplexy
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Suicidal
(Signed) F. [illegible] M. D.
6/4/30 19 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem. | Date of Burial 19

20. Undertaker: E. T. Peck | Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70903

PLACE OF DEATH

County of Blaine
City of Hailey
Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 22
(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Francis C. Reardon

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary

6. DATE OF BIRTH (month, day and year) Sept 17 - 1902

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey - Ida.

PARENTS

10. NAME OF FATHER Daniel Reardon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iceland
12. MAIDEN NAME OF MOTHER Mary Quigley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dubuque Iowa

14. Informant J. J. Reardon
(Address) Hailey - Idaho

15. Filed 7 - 1, 1930 P. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/21/30, 19..., to 6/1, 1930, that I last saw h~~im~~ alive on 6/1 - 1930, and that death occurred, on the date stated above, at 7-40 P. m.

The CAUSE OF DEATH* was as follows:
Spotted (Tick) Fever
(duration) ... yrs. ... mos. 9 ds.
CONTRIBUTORY (Secondary) Mitral Lesion -
(duration) ... yrs. ... mos. 9 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. W. Fox, M. D.
6/2, 1930 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Idaho	June 4 1930
20. Undertaker	Address
Harris & Conner	Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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MARGIN RESERVED FOR BINDING

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RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70905

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boise
City of Casner Ranch

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 50
(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth B Redsull
(a) Residence. No. Casner Ranch St. Boise County
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James S. Redsull

6. DATE OF BIRTH (month, day and year) Feb 28 1853

7. AGE Years 77 Months 3 Days 15 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Alexander G. Graham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Elizabeth Bauchap
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant (Address) Mrs. H. B. Herrick Pt Angeles Wash

15. Filed 6-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 14, 1930
that I last saw her alive on June 13, 1930
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senile Dementia and Leakage of valves of heart
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French, M. D.
June 16, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Casner Ranch Date of Burial 6/16 1930

20. Undertaker Schneider & McBaum Address Boise

RECEIVED JUL 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE.
State File No. .....

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boise

City of Casner's Ranch

Registration District No. 8

Primary Registration District No. 2004 Local Registrar's No. 49

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliz. B. Redsull

(a) Residence. No. Casner Ranch St. Boise County
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of James S. Redsull

6. DATE OF BIRTH (month, day and year) 2-28-1853

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HW
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10. NAME OF FATHER Alexander G. Graham

11. BIRTHPLACE OF FATHER (city or town) Scotland
(State or Country)

12. MAIDEN NAME OF MOTHER Eliz. Bauchap

13. BIRTHPLACE OF MOTHER (city or town) Scotland
(State or County)

14. Informant Mrs. H. B. Herrick
(Address) Port Angeles, Wn.

15. Filed 6-18-30, 19.... W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
5-31-30, 19...., to 6-14-30, 19....
that I last saw her alive on 6-13-30, 19....
and that death occurred, on the date stated above, at 2 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

SENILE DEMENTIA AND LEAKAGE
OF VALVES OF HEART

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY
(Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) P.P. French, M. D.
6-16-30, 19.... (Address) Boise, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Casner Ranch	6-16-30 19
20. Undertaker	Address
Schreiber & McCann	Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70906

PLACE OF DEATH
County of Boise
~~near~~ Lowman

Registration District No. .....
Primary Registration District No. 2004 Local Registrar's No. 50
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1940

2. FULL NAME ANDREW PHELPS
(a) Residence. No. 220 North 6th Boise St. Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE ~~65~~ 64 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Highway work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Philadelphia, Pa.

PARENTS
10. NAME OF FATHER Andrew Phelps
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Birmingham England.
12. MAIDEN NAME OF MOTHER Mary Hopkins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dublin Ireland

14. Informant (Address) E. J. Phelps Brother of deceased Omaha, Nebr.

15. Filed 6-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ was Killed in Auto Accident ~~that I last saw h~~ ~~alive on~~ June 15th 1930 and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Was Killed in Auto Accident June 15th 1930 near Lowman, Boise, County, Idaho
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Mr Duguest held
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. W. Schlosser, M.D.
19 (Address) Coroner of Boise, County Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery | Date of Burial 6/18 1930

20. Undertaker Schreiber & Wm Cauer | Address Boise.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
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RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70906

PLACE OF DEATH

County of Boise
City Nea Lowman

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004 . Local Registrar's No. 51
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

144 C

2. FULL NAME Andrew Phelps

(a) Residence. No. 220 North Cr St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 64 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Helen

9. BIRTHPLACE (city or town) (State or country) Fr

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Information

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address)

15. Filed 6-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidentally killed by Automobile

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) S. Wilson Cox M. D.
....., 19..... (Address) Boise Co

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 6/18 1930

20. Undertaker: Schreiber & Wm. Cain
Address: Boise

RECEIVED JUN 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70907

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Boise
City of Placerville

Registration District No. 12
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

2. FULL NAME James B Wilson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

205 B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years 69 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant
(Address)

15 Filed , 19 Mrs E S Robison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 16 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from No Attendance, 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Not known - found dead in bed, death probably due to natural causes
No inquest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. N. Becker, M. D.
June 18 1930 (Address) Quartzburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Placerville Idaho
Date of Burial: June 20 1930

20. Undertaker: Mr McCarne
Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70908

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 10

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar Tufte

(a) Residence. No. St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	50			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Hayfield (State or country) Minn

PARENTS

10. NAME OF FATHER Ole Tufte

11. BIRTHPLACE OF FATHER (city or town) Oslo (State or Country) Norway

12. MAIDEN NAME OF MOTHER Christiana Dahl

13. BIRTHPLACE OF MOTHER (city or town) Quebec (State or Country) Canada

14. Informant Mrs Thelma Stroh
(Address) 219 6th Athdeen Wash.

15. Filed June 28, 1930 R. E. Wesna Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27th. (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 7 P. m.
The CAUSE OF DEATH* was as follows:

Unknown
Probable Chronic Heart Disease.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. D. Moon, Coroner. M. D.
June 28, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash	July 2, 1930

20. Undertaker Address
Moon Mortuary Priest River

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70909

PLACE OF DEATH
County of Bonner
City of Newport

Registration District No. 83
Primary Registration District No. 2185
Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stanley Lafeffe Stanton

(a) Residence. No. St. Newport, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 15-1915

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	4	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER L. N. Stanton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Lula Davenport
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant L. N. Stanton
(Address) Newport, Wash.

15. Filed June 7, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. N. Stanton Coroner
June 7, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Newport, Wn.	June 8 1930

20. Undertaker Sherman & Davis — Address Newport, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70910

PLACE OF DEATH
County of Bonner
City of Newport

Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 8
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emil Clausnitzer 142
(a) Residence. No. ..... St. Newp
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 17, 1917

7. AGE Years 12 Months 07 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dodson, Montana

PARENTS

10. NAME OF FATHER Paul A. Clausnitzer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Julia Kittelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Dakota

14. Informant Paul A. Clausnitzer
(Address) Newport, Wash.

15. Filed June 7, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) L. H. Moon Coroner
June 7, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Newport, Wash. Date of Burial June 8 1930

20. Undertaker Sherman & Davis Address Newport, Wn.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70911

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 7f
Primary Registration District No. 255
Local Registrar's No. 52
(No.) 64
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ella Marie Montgomery

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. I yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 6, 1923

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	I	I7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montrose County Colorado

PARENTS

10. NAME OF FATHER H. H. Montgomery
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oskaloosa Iowa
12. MAIDEN NAME OF MOTHER Melba Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mound City Kansas

14. Informant H. H. Montgomery
(Address) Elmira, Idaho.

15. Filed June 27, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 23, 1930
that I last saw her alive on June 23, 1930
and that death occurred, on the date stated above, at 1:30 P m.
The CAUSE OF DEATH* was as follows:
Anemia of the Spleen

(duration) yrs. One mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. J. Peet D.O., M.D.
June 25, 1930 (Address) Sandpoint - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Elmira, Idaho, NW¼ NW¼ Sec. — Date of Burial: June 26, 1930
20. Undertaker: Moon Mortuary — Address: Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Ella Marie Montgomery

now lying buried in Private Family Cemetery, in the City or Town of Near Elmira

County of Bonner State of Idaho, who died on the 23 day of June, 1930, Aged 7 years ____ months

____ days, the cause of death being Anemia of the Spleen and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

T. J. Peet, D.O. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Pinecrest Cemetery in the City or Town of Sandpoint County of Bonner

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Bonner it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 4th day of September, A.D. 19 70.

Permit issued to:
Dale G. Coffelt
Coffelt Funeral Service Inc.
Sandpoint, Idaho

W. M. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____
Health Officer

FORM BH 56-019

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70912

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 51

88B

2. FULL NAME Estella Pearl Wood

(a) Residence. No. ..... St. Clagstone, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 21, 1914

7. AGE 16 Years 2 Months 29 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Florence, Colo.

PARENTS

10. NAME OF FATHER James R. Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jackson County Colo.
12. MAIDEN NAME OF MOTHER Sceena Kent.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas Creek Colo.

14. Informant Mrs. J. R. Wood.
(Address) Clagstone, Idaho.

15. Filed June 21, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20, (Day) 1930, (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, June 20, 1930
that I last saw her alive on June 19, 1930
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis following empyemia.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Wendle, M. D.
June 21, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery. Date of Burial June 22 1930

20. Undertaker R. E. Wessa. Address Priest River, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70913

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 50

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Jennie Christianson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Christianson

6. DATE OF BIRTH (month, day and year) Apr. 17, 1867

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	1	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Hans Gulbrandson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Peter Christianson
(Address) Sandpoint, Idaho.

15. Filed June 2, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 30, 1930, that I last saw her alive on May 30, 1930 and that death occurred, on the date stated above, at 10:15 p m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Wm F. Tyler, M. D.

June 2, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 2, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70914

Local Registrar's No. 49

PLACE OF DEATH

County of Bonner
City of Morton
Registration District No. 78
Primary Registration District No. 2155
(No. Morton, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME William T. Milliken

(a) Residence. No. ..... St. Morton, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nancy Jane Milliken

6. DATE OF BIRTH (month, day and year) March 31, 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	2	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Joseph Milliken
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Mary H. Tripp
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Ida Milliken
(Address) Morton, Ida.

15. Filed June 11, 1930 Viola Alley Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 8, 1930
that I last saw him alive on June 8, 1930
and that death occurred, on the date stated above, at 10:50 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorage

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. D. P. [illegible], M. D.
June 11, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spangle, Wn.	19 June 12, 30

20. Undertaker Moon Mortuary Address Sandpoint

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70915

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
Local Registrar's No. 48
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME William Eckhart.

(a) Residence. No. So Lavina St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Elizabeth Eckhart.

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs. Cora Lemay
(Address) Oak St. Sandpoint Idaho.

15. Filed June 10, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930 to June 8, 1930
that I last saw him alive on June 7, 1930
and that death occurred, on the date stated above, at 7:15 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd G Wyatt M.D.
June 10, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	June 10, 1930

20. Undertaker Moon Mortuary Address Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70916

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

161a

2. FULL NAME Francis Vander Pas
(a) Residence. No. North Boyer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6, 1930

7. AGE Years | Months | Days 24 hrs. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho

PARENTS

10. NAME OF FATHER Frank Vander Pas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Barbara Wetsch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Glendive Mont

14. Informant Frank Vander Pas
(Address) North Boyer Sandpoint Ida

15. Filed June 7, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th, 1930, to June 7th, 1930
that I last saw him alive on June 6th, 1930
and that death occurred, on the date stated above, at 7 a. m.
The CAUSE OF DEATH* was as follows:
Premature birth in 8th month of gestation. Patulous Foramen Ovale
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. B. Evans, M. D.
6-7, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine crest | Date of Burial: June 7 1930

20. Undertaker: Moon Mortuary | Address: Sandpoint Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70917

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 [illegible]

Local Registrar's No. 97

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

65-6

2. FULL NAME John Cutler Williams

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 1897

7. AGE: Years 32 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clyde Idaho

PARENTS

10. NAME OF FATHER: Henry Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Dent Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Arthur Ward McKinley
(Address): Blackfoot Idaho

15. Filed May 2, 1930 Route 2 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 9, 1930
that I last saw him alive on May 9, 1930
and that death occurred, on the date stated above, at 4 m.
The CAUSE OF DEATH* was as follows:
Myelogenous Leukemia
..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Blackfoot, Idaho
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [illegible], M. D.
....., 19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thorn & Riverside | Date of Burial: 19

20. Undertaker: E J Peck | Address: Blackfoot

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70918

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 7310-0
Local Registrar's No. 9
(No. L D S Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1014

2. FULL NAME George Monroe Burke

(a) Residence. No. Iona, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Fanny Isabell Burke

6. DATE OF BIRTH (month, day and year) Mar. 23, 1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	1	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER William Burke
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Josephine Huddle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant L. M. Burke
(Address) Iona, Ida.

15. Filed May 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 10, 1930
that I last saw him alive on May 10, 1930
and that death occurred, on the date stated above, at 12-30 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Myocarditis Chron.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Iona
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.
5/13, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona, Idaho	May 13 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70919

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 99
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore Roch. 41

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 11-1905

7. AGE: Years 24 | Months 7 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salmon Ida.

PARENTS

10. NAME OF FATHER: George Roch.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Texas
12. MAIDEN NAME OF MOTHER: Ella Richardson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho Falls Ida.

14. Informant: Mrs H. Dutton.
(Address) Idaho Falls Ida.

15. Filed May 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8, 1930, to May 11, 1930
that I last saw him alive on May 11, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Septicemia
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Streptococci Infection Throat
..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: May 14 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

PLACE OF DEATH

County of Bonniville

City of Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70920

Local Registrar's No. 100

10 B

2. FULL NAME Dean Harry Fell

(a) Residence. No. 772 K St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. 7 How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 6th 1930

7. AGE Years Months 1 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls

PARENTS

10. NAME OF FATHER Harry Fell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Solma Danelson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Fairfield Ida

14. Informant Harry Fell
(Address) Idaho Falls Idaho

15. Filed May 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12th, 1930, to May 13th, 1930 that I last saw him alive on May 12th, 1930 and that death occurred, on the date stated above, at 8:10 A.m.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(duration) yrs. mos. One day

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Ascultation & Percussion

(Signed) Thomas C. Willson, M. D.

May 13, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby Cemc, Date of Burial: May 15, 1930

20. Undertaker: Vern J. Keller Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70921

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-D

Local Registrar's No. 101

(No. Spencer Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Catharine Smalley

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 25 1866

7. AGE: Years 63, Months 7, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leavenworth Kansas

PARENTS

10. NAME OF FATHER A. E. Hogan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bangor Maine

12. MAIDEN NAME OF MOTHER Mary Dawson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York N.Y.

14. Informant Mrs Eugene Trask
(Address) Idaho Falls Ida

15. Filed May 14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 30, 1929, to May 13, 1930 that I last saw her alive on May 13, 1930 and that death occurred, on the date stated above, at Midday m

The CAUSE OF DEATH* was as follows: Chronic Valvular heart disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

May 14, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 5/16 1930

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida

Dr Hatch

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70923

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 103
(No. Idaho Falls, L.D.S.Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

40

2. FULL NAME Clyde Clinton Montgomery.

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 2 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	5	20	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER David C. Montgomery

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Margaret E. Adams.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant David C Montgomery
(Address) Rigby Idaho

15. Filed May 21, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1930 to April 22 1930
that I last saw him alive on April 22 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Baby was in Continual convulsions during 4 hours in hospital. No Diagnosis was made (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY —
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) W Ray Hatch, M. D.
April 23, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho.	4/24/30 19

20. Undertaker [illegible] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70924

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 214-0
Local Registrar's No. 104
(No.) 21
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Watson Coder
(a) Residence. No. 340-E-18th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 16 - 1842
7. AGE Years 87 Months 7 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Wm Coder.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant John E Coder.
(Address) Idaho Falls Ida
15. Filed May 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21 1930.
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to May 21, 1930
that I last saw ~~him~~ alive on May 20, 1930
and that death occurred, on the date stated above, at 9.05 A. m.
The CAUSE OF DEATH* was as follows:
Erysipelas
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Chronic endocarditis
(duration) 0 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical course
(Signed) [signature], M. D.
May 22, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clifton Kansas. Date of Burial: May 25 1930
20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70925

Local Registrar's No. 104

PLACE OF DEATH

County of Bonneville. Registration District No. 3

City of Idaho Falls. Primary Registration District No. 3-14-2

(No. 25 U. S. Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geraldine Eggleston. 119

(a) Residence. No. Iona (Usual place of abode) Idaho St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 18 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	3	3.	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho.

PARENTS

10. NAME OF FATHER Harry Eggleston.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boulder Colo.

12. MAIDEN NAME OF MOTHER Minnie May Browning.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lorenzo Ida

14. Informant Harry Eggleston.

(Address) Iona Idaho

15. Filed May 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. May (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 20, 1930

that I last saw h alive on May 20, 1930

and that death occurred, on the date stated above, at 11,15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nes - Colitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Iona Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) [signature], M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Annis Idaho	May 23 1930

20. Undertaker W. F. McHan Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70927

PLACE OF DEATH

County of Bonneville
City of Idaho Falls Idaho.

Registration District No. 73
Primary Registration District No. 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 124

14

2. FULL NAME Annie May Nold

(a) Residence. No. Idaho Falls RFD #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. Idaho How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph C Nold.

6. DATE OF BIRTH (month, day and year): May 10 1888

7. AGE: L Years: 42 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Conant Valley, Idaho

PARENTS

10. NAME OF FATHER: Joseph N Hay Higham
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah.
12. MAIDEN NAME OF MOTHER: Margaret Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ogden Utah.

14. Informant: R C Nold
(Address) Idaho Falls Idaho

15. Filed 6/15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1929, to June 13, 1930
that I last saw her alive on June 12, 1930
and that death occurred, on the date stated above, at 7.40 P. m.
The CAUSE OF DEATH* was as follows:
Metastatic Adenocarcinoma of Intra Viscera
(duration) yrs. 10½ mos. ds.
CONTRIBUTORY (Secondary) Ruptured Adenocarcinoma of ovary
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Aug 3, 1929
Was there an autopsy? no
What test confirmed diagnosis? Pathological
(Signed) [signature], M. D.
June 18, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho — Date of Burial: 6/ 1930

20. Undertaker: J A Wood — Address: Idaho Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70928

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

100a

2. FULL NAME Arthur Lawrence Lindstrom

(a) Residence. No. ..... St. Lewisville, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24, 1930

7. AGE Years Months 1 Days 30 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewisville, Idaho

PARENTS
10. NAME OF FATHER Gust Lindstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Ethel Rydberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chicago, Illinois

14. Informant Gust Lindstrom
(Address) Lewisville, Idaho

15. Filed 6/14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 14, 1930
that I last saw him alive on June 14, 1930
and that death occurred, on the date stated above, at 8 a m.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Myelogenous Leucemia

(duration) ..... yrs. ..... mos. ? ds.

18. Where was disease contracted if not at place of death? Roberts, Idaho
Did an operation precede death? Spinal puncture only Date of
Was there an autopsy? No Phonoentesis also
What test confirmed diagnosis? Clinical & Blood

(Signed) [signature], M. D.
June 17, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewisville, Idaho
Date of Burial June 15 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70929

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. I. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

2. FULL NAME Sarah Emma Smith
(a) Residence. No. ..... St. Rigby Route #2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: B. T. Smith

6. DATE OF BIRTH (month, day and year): May 22 1894

7. AGE: Years 36 | Months | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelton, Idaho

PARENTS
10. NAME OF FATHER: Willard Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Goshen, Utah
12. MAIDEN NAME OF MOTHER: Annie L. Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spanish Fork, Utah

14. Informant: Willard Moore
(Address): Rigby Route #2

15. Filed 6/14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to June 12, 1930
that I last saw her alive on June 12, 1930
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Two days following thyroidectomy for toxic adenomatous goiter
(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary) 6 month pregnancy dead fetus
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 11, 1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Lab
(Signed) H. Ray Hatch, M. D.
6/14, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ririe, Idaho | Date of Burial: June 15 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70930

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 121

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME John Edward Schofield
(a) Residence. No. 284 West 14th St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hannah E. Schofield

6. DATE OF BIRTH (month, day and year) June 24, 1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	10	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Joseph Schofield
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Fields
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs. Hannah E. Schofield
(Address) Idaho Falls, Idaho

15. Filed 6/12, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21, 1928, to May 5, 1929
that I last saw h[illegible] alive on May, 1930
and that death occurred, on the date stated above, at 3-30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the rectum
(duration) 3 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) W Ray Hafich M. D.
June 12, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	June 16 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70931

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 120

88 B

2. FULL NAME Lucy H. Parker
(a) Residence. No. ..... St. Ogden, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Parker

6. DATE OF BIRTH (month, day and year) September 11, 1865

7. AGE Years 64 Months 8 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kaysville, ~~Idaho~~ Utah

PARENTS
10. NAME OF FATHER William Priest
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Martha Allmark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant John Parker
(Address) Ogden, Utah

15. Filed 6/17, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7th, 1930, to June 10, 1930
that I last saw her alive on June 10, 1930
and that death occurred, on the date stated above, at 7-55 p m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis and Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) A. R. Sodenquist, M. D.
June 12, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Taylor, Idaho
Date of Burial June 13 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70932

Registration District No. 73
Primary Registration District No. 2710
Local Registrar's No. 119

117

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No.) L. D. S. Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Jeppesen Owen
(a) Residence. No. 310 - 8th Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Lewis M. Owen

6. DATE OF BIRTH (month, day and year): January 16 1903

7. AGE: Years 27 | Months 4 | Days 25 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: J. W. Jeffery
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Effie Reid
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Lewis M. Owen
(Address) 310 - 8th St. Idaho Falls, Idaho

15. Filed 6/12, 1930 Effie Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 11 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1930, to June 11, 1930
that I last saw h[illegible] alive on June 11, 1930
and that death occurred, on the date stated above, at 2:30 a.m.
The CAUSE OF DEATH* was as follows:
Acute Suppurative Appendicitis
Acute Septicemia

(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 5-1930
Was there an autopsy? No
What test confirmed diagnosis? Surg
(Signed) A. P. Sodgrass M. D.
June 12, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: June 14 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70933

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2100
(No. L. D. S. Hospital)
Local Registrar's No. 11
(If death occurred in a hospital or institution, give its name instead of street and number.)
183

2. FULL NAME John J. Johnson

(a) Residence. No. ____ St. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day,
About	20			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Not Known
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Dakota

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Joshua L. Brown
(Address) Idaho Falls, Idaho

15. Filed 6/11, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__
that I last saw h__ alive on ____, 19__
and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:
Gun shot Wound
accidental
party unknown
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY
(Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) [signature] M. D.
June 11, 1930 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho — Date of Burial June 11 1930

20. Undertaker Jack G. Wood — Address Idaho Falls

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70934

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 7 0
Local Registrar's No. 11
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME William Saunders Warehan

(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Warehan

6. DATE OF BIRTH (month, day and year): Oct 28, 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Service Station Properitor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: George Warehan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Margaret Jane Robbins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: H. C. Warehan
(Address): Idaho Falls, Idaho

15. Filed 6/9, 1930 C. A. Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 6, 1930
that I last saw him alive on June 6, 1930
and that death occurred, on the date stated above, at 8-15-a m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Enlarged Prostate
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June 5-30
Was there an autopsy? yes
What test confirmed diagnosis?

(Signed) C. A. Freeman, M. D.
June 9, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho	June 8 1930
20. Undertaker: Jack G. Wood	Address: Idaho Falls

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70935

PLACE OF DEATH

County of Bonneville Registration District No. 23
City of Idaho Falls Primary Registration District No. 2 1 N 2
(No. none)
Local Registrar's No. 137

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Leane George Case. 9

(a) Residence. No. North of City on Pavis St. Road.
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male. | 4 COLOR OR RACE: white. | 5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 26-1930

7 AGE — Years: 0 | Months: 1 | Days: 5 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho Falls. Ida.

PARENTS

10 NAME OF FATHER: Leane Case.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Emery. Utah.

12 MAIDEN NAME OF MOTHER: Estella Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Blackfoot. Ida.

14 Informant: Dave Case.
(Address): Idaho Falls. Ida.

15 Filed 7/7, 1930 C. Townsend Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 1 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 1st, 1930, that I last saw h.... alive on July 1st, 1930 and that death occurred, on the date stated above, at [redacted] P. m.

The CAUSE OF DEATH* was as follows: Pertussis and Pneumoni

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. W. Pendleton M. D.

July 2, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 7/2 1930

20. Undertaker: W. F. McVay | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70936

Local Registrar's No. 136

143a

PLACE OF DEATH

County of Bonneville Registration District No.

City of Idaho Falls Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Christiana Mussman.

(a) Residence. No. 3 Miles North of I. F.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 15 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kana. Russia.

PARENTS

10 NAME OF FATHER Geo Cline.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER Katharine Doch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Jacob. Mussman

(Address) Idaho Falls Ida

15 Filed 7/7, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 5 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 7/5/30. 5.55 a.m., to 7/5/30 6 a.m.

that I last saw h[illegible] alive on , 19

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage following Spontaneous Abortion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/7/30, 19 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 7/ 19 30

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70937

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21V-0
(No. L.D.S. Hospital)
Local Registrar's No. 134
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verda Johnson

(a) Residence. No. 161A St. Teneton Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25, 1930

7. AGE — Years | Months | Days | If LESS than 1 day, 3 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida

PARENTS

10. NAME OF FATHER: V. L. Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Preston Idaho

12. MAIDEN NAME OF MOTHER: Verna Keller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: V. L. Johnson
(Address) Teneton Ida.

15. Filed 6/26, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 25, 1930
that I last saw her alive on June 25, 1930
and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. 6h mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

June 26, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls — Date of Burial: June 26 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70938

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 2,150 Local Registrar's No. 134

(No. Spencer Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Florence Hart

(a) Residence. No. Roberts Ida. St. 129

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W. Hart.

6 DATE OF BIRTH (month, day and year): May 1-1894

7 AGE: Years 36. Months 1 Days 22. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Deer Lodge Montana.

PARENTS

10 NAME OF FATHER: Alfred H. Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Geneva Ferguson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Geo W. Hart.

(Address) Roberts Idaho

15 Filed 6/25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 23. 1930 (Month) (Day) (Year)

~~June 15~~

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 23, 1930, that I last saw her alive on June 23, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Parenchymatous

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) A. R. Sodermont, M. D.

June 25, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls. Ida. Date of Burial: 6/25 1930

20. Undertaker: V. F. McHan. Address: Idaho Falls Ida

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70939

PLACE OF DEATH

County of Bonneville
City of Idaho Falls, Ida

Registration District No. 73
Primary Registration District No. 2 1 V-0
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 133

161a

2. FULL NAME Laura Elizabeth Ball

(a) Residence. No. ..... St. Idaho Falls Rt #2
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 23, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, 2 hrs. and 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER E. Berry Ball
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Elizabeth Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grass, Idaho

14. Informant E B Ball
(Address) Idaho Falls Rt #2

15. Filed 6/24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 23 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 23, 1930 that I last saw her alive on June 23, 1930 and that death occurred, on the date stated above, at 10:00 a. m.

The CAUSE OF DEATH* was as follows:

Premature birth
7½ months
(duration) yrs. mos. 2 hrs ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
6/24 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 6/24 1930

20. Undertaker: [signature] | Address: Dutch Sales Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70940

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 132

92

2. FULL NAME Martha Ellen Outson

(a) Residence. No. ..... St. Ririe, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William Outson

6. DATE OF BIRTH (month, day and year): Jan 31, 1871

7. AGE: Years 59 | Months 4 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Oak City, Utah

PARENTS

10. NAME OF FATHER: Joseph Lovell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Leah Ellen Radford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Provo, Utah

14. Informant: James W. Lovell
(Address): Ririe, Idaho

15. Filed 6/23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 21, 1930
that I last saw her alive on June 21, 1930
and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:
Embolism, Right subclavian artery
..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis
obesity ..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H Ray Hatch, M. D.
June 22, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelton, Idaho | Date of Burial: June 23 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70941

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 131

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. FULL NAME Ulella Mellisa Palmer
(a) Residence. No. Ucon, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 25, 1928

7. AGE: Years 2 | Months | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ucon, Idaho

PARENTS

10. NAME OF FATHER: Eshel Oscar Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Peoa, Utah
12. MAIDEN NAME OF MOTHER: Elva Burdick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Geo Palmer
(Address) Ucon, Idaho

15. Filed 6/21, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11 A.M. 6/18, 1930, to 1 A.M. 6/19, 1930
that I last saw her alive on June 19, 1930
and that death occurred, on the date stated above, at 1 a m.
The CAUSE OF DEATH* was as follows:
Meningococcus Meningitis
Sporadic case
14 Hrs. (duration) ~~yrs.~~ ~~mos.~~ ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Dr [signature] M.D.
June 20, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ucon, Idaho | Date of Burial: June 20 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 70942

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 2 1 1 0

(No. .....)

Local Registrar's No. 130

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mina Bieman

(a) Residence. No. 3 miles So of Idaho Falls. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bieman

6 DATE OF BIRTH (month, day and year): Jan 1-1842

7 AGE: Years 88 Months 5 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Letz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Otto Bieman

(Address) Idaho Falls Ida

15 Filed 6/20, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 18 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1928, to June 16, 1930, that I last saw her alive on Sept 23, 1928, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of neck and back.

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. R. Sodenquist, M. D.

June 19, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Peterson Iowa

Date of Burial: 6/23 1930

20. Undertaker: V. F. McHan

Address: Idaho Falls Ida

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70943

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 2152

Local Registrar's No. 129

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Mrs Sarah Forbush

(a) Residence. No. Victor Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

101a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of S. Forbush

6 DATE OF BIRTH (month, day and year) April 10-1878

7 AGE: Years 52 Months 2 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pleasant Grove Utah

PARENTS

10 NAME OF FATHER Frank Fenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y. State

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Sam Forbush

(Address) Victor Idaho

15 Filed 6/19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 25 1930, to June 18, 1930, that I last saw her alive on June 17, 1930 and that death occurred, on the date stated above, at 1054 m.

The CAUSE OF DEATH* was as follows: Labor Pneumonia and Empyaemia

(duration) ..... yrs. ..... mos. 22 ds.

CONTRIBUTORY (Secondary) Chronic valvular endocarditis (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Bray

(Signed) H Ray Hatch M. D.

June 18, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 6/20 1930

20. Undertaker: V. F. McHan. Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70945

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No.
Primary Registration District No.
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 127

101a

2. FULL NAME Heber C Wilkins

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. ✓ mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 7 - 1864

7. AGE Years 66 Months 7 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer (So Cottonwood Utah)

9. BIRTHPLACE (city or town) (State or country) So Cottonwood Utah

PARENTS

10. NAME OF FATHER Chas. Wilkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Ura Welsh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Andrew Wilkins
(Address) Ucon. Idaho

15. Filed 6/10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/13, 1930, to 6/16/30, 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 8.30 A.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R Button M.D.
6/18/30 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ucon Ida
Date of Burial 6/19. 1930

20. Undertaker V. F. McHan
Address Idaho Falls Idaho

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70946

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 12 14-6 Local Registrar's No. 126

(No. St. L. D. L. Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Martha May Jumps. 13 3

(a) Residence. No. Grovont St. Wyo.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Tom Jumps.

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10 NAME OF FATHER Warren Edmiston

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Lucy Wolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Tom Jumps.

(Address) Grovont. Wyo.

15 Filed 6/18, 1930 Wm. Fiemaid Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to June 18, 1930
that I last saw h. alive on June 18, 1930
and that death occurred, on the date stated above, at 2:3 P m.

The CAUSE OF DEATH* was as follows: Chronic Cholecystitis
Surgical Shock.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Grovont Wyo

Did an operation precede death? yes Date of June 18/30

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) A. P. Sudmeyer, M. D.

6/18, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Wilson Wyo.	6/22 1930
20. Undertaker	Address
W. F. McFarland	Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 V-0

(No. ..... , ... St.)

File No. 70917

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Senath A. Atchley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Jan (Month) 19th (Day) 1910 (Year)

7. AGE: 20 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Marysville

10. NAME OF FATHER: H. W. Hess.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Vera. Potter.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. W. Hess.

(Address) Marysville.

15. Filed 6/17 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

118 (b)

16. DATE OF DEATH: June (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1930, to June 17 1930, that I last saw h..... alive on June 17 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Intestinal obstruction

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) adhesions

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) H Ray Hatch M. D.

June 17 1930 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marysville Cem. DATE OF BURIAL: June 19 1930.

20. UNDERTAKER: Vern. J. Keller. ADDRESS: Rexburg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70948

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2 19 9
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

1810

2. FULL NAME William Albert Henderson

(a) Residence. No. ..... St. ..... Joseph, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha Henderson

6. DATE OF BIRTH (month, day and year) April 1, 1888

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	2	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clifton, Idaho

PARENTS

10. NAME OF FATHER Horace Henderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brigham City, Utah
12. MAIDEN NAME OF MOTHER Harriett Van Leuven
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Preston Utah

14. Informant George R. Henderson
(Address) Logan, Utah

15. Filed 6/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 8, 1930
that I last saw h[illegible] alive on June 8, 1930
and that death occurred, on the date stated above, at 11-20 P m.

The CAUSE OF DEATH* was as follows:
Left Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W Ray Hale M. D.
June 9, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Joseph, Utah	June 11 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70949

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
(No. I. F. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME William A. Hian

(a) Residence. No. ..... St. Iona, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice Jane Hian

6. DATE OF BIRTH (month, day and year) July 1, 1857

7. AGE: Years 72 | Months 11 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: John Henry Hian
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Mary Sims
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs William A Hian
(Address) Iona, Idaho

15. Filed 6/6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 3, 1930
that last saw h[illegible] alive on June 3, 1930
and that death occurred, on the date stated above, at Noon m.

The CAUSE OF DEATH* was as follows:
General Peritonetes & Rupture of Small intestins
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Injury received (Strike) Abdomen against post (fall from horse
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) [signature], M. D.
6-6-, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho	June 6 1930
20. Undertaker: Jack G. Wood	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70950

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 2-10-0
(No. L. U. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 114

101a

2. FULL NAME John Sanders Lords
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Isbelle Lords

6. DATE OF BIRTH (month, day and year): Oct 12, 1862

7. AGE: Years 67 | Months 7 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pleasant Grove Utah

PARENTS
10. NAME OF FATHER: William Lords
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Mary Lords
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. John S. Lords
(Address): Idaho Falls, Idaho

15. Filed 6/1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 3, 1930
that I last saw him alive on June 3, 1930
and that death occurred, on the date stated above, at 10-25a m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary): Myocarditis, acute
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? 138 - 10th
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
June 5, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho | Date of Burial: June 5 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70951

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21450
(No. L. H. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 113

96

2. FULL NAME Lorena Ruth Bateman
(a) Residence. No. ..... St. Shelley, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Christopher Bateman

6. DATE OF BIRTH (month, day and year): February 3, 1870

7. AGE: Years 60 | Months 3 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Murray, Utah

PARENTS

10. NAME OF FATHER: Jesse Higgins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Louisa Ann Swinyard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: H. A. Bateman
(Address): Shelley, Idaho

15. Filed 6/4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY that I attended deceased from 5-20, 1930, to 5-30, 1930
that I last saw her alive on 5-30-, 1930
and that death occurred, on the date stated above, at 1 p m.
The CAUSE OF DEATH* was as follows:
Hyper-glycemia + General Metabolic Dyscrasia
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary): Obesity
(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory Blood + Urinal
(Signed) Edwin Cutler, M. D.
5-31-, 1930 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelley, Idaho | Date of Burial: June 4 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70952

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2170
Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Carlyle Pelot.
(a) Residence. No. Idaho Falls R.N. 2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of Mrs C. E. Pelot.
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 18 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	0	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10. NAME OF FATHER Francis E. Pelot.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia.
12. MAIDEN NAME OF MOTHER Elizabeth Carlyle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky.

14. Informant Mrs C. E. Pelot.
(Address) Idaho Falls Ida.

15. Filed June 2, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 -, 1930, to May 17th, 1930
that I last saw him alive on May 17th, 1930
and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows:

Diabetes complicated
Myocarditis
(duration) about 1 year yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Chemical Analysis
(Signed) Thomas C. Miller, M. D.
May 31, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls.	June 2 1930

20. Undertaker W. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70953

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21-J
(No. L. D. S. Hospital)
Local Registrar's No. 111
100a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth LaVell Jensen

(a) Residence. No. ..... St. Payette Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 1, 1929

7. AGE — Years: 1 — Months: 4 — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country) Payette, Idaho

PARENTS

10. NAME OF FATHER Kenneth Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyrum, Utah
12. MAIDEN NAME OF MOTHER Effie Jennings
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho, Idaho

14. Informant Kenneth Jensen
(Address) Payette, Idaho

15. Filed 6-2, 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to May 30, 1930
that I last saw him alive on May 30, 1930
and that death occurred, on the date stated above, at 11-30a m.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? 275 - 1st St
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) ..... M. D.
5/31, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona, Idaho — Date of Burial: June 2 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70955

County of Bonneville
City of Idaho Falls

Registration District No. 72
Primary Registration District No. 2140
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution give its name instead of street and number.)

Local Registrar's No. 09

7/10

2. FULL NAME Harvey F. Sott

(a) Residence. No. ..... St. Joseph, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 2, 1912

7. AGE — Years: 17 | Months: 5 | Days: 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Joseph, Utah

PARENTS

10. NAME OF FATHER: Peter Sott
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Randolf, Utah
12. MAIDEN NAME OF MOTHER: Isabella Transmith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bigny, Utah

14. Informant: Peter Sott
(Address) Joseph, Utah

15. Filed May 27, 1930 Wm. Thomas Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to May 25, 1930
that I last saw him alive on May 25, 1930
and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Staphlococcus Cerebro-Spinal Meningitis

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Utah
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Spinal punctures

(Signed) J. Sprott, M. D.
May 25, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Joseph, Utah	May 28 1930
20. Undertaker: Jack A. Wood	Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70956

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 1/2
Local Registrar's No. 10 P.
(No. E. H. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George T. Jackson
(a) Residence. No. Cokeville Wyo. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ✓ yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5-1875

7. AGE: Years 54, Months 8, Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nephi Utah

PARENTS
10. NAME OF FATHER: Silas H. Jackson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Harriett Ellis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs W. W. Heath
(Address) Idaho Falls Ida

15. Filed May 27, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 24, 1930
that I last saw her alive on May 24, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Septicemia
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary): Lymphangitis following tic bite
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Cokeville, Wyo
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: 5/27 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70957

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 4 0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

8813

2. FULL NAME Joseph A. Biver
(a) Residence. No. 729 - 10th Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Biver

6. DATE OF BIRTH (month, day and year) June 20, 1857

7. AGE Years 72 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant O. Biver
(Address) Idaho Falls, Idaho

15. Filed May 24, 1930 Co. Kimmard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to May 19, 1930
that I last saw him alive on May 18, 1930
and that death occurred, on the date stated above, at 3.30 p m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis and chronic endocarditis
Indefinite (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Acute Cardiac dilatation
(duration) ..... yrs. Short mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Mellar M. D.
May 24, 1930 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho Date of Burial May 1930

20. Undertaker Jack A. Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70958

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 84

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Wilmer Henry Kohle

(a) Residence. No. 220-17Ave S. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec, 16 1921

7. AGE: Years 8, Months 6, Days 9. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Ida.

PARENTS

10. NAME OF FATHER H.A. Kohle.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Johanna Hartman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant H.A. Kahle.
(Address) Nampa, Ida.

15. Filed 6-24, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930 to June 25, 1930 that I last saw him alive on June 22, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

..... (duration) 2 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Rheumatic Endocarditis

..... (duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V C Bellmap, M. D.

6-25, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem

Date of Burial: 6-29 1930

20. Undertaker: F. K. Robinson

Address: Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70959

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 1711 - 4st So Nampa Ida)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 83

49

2. FULL NAME Mary Nielson
(a) Residence. No. 1711 - 4 St So St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 14 -

7. AGE Years 65 Months 10 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER C Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Mary Ann Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant
(Address)

15. Filed 6-25, 1930 Bertha Conway Registrar

V.C.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930 to June 25, 1930
that I last saw her alive on June 25, 1930
and that death occurred, on the date stated above, at 10 10 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. 32 hours
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) O C Bellmap M. D.
June 25, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlown Cem
Date of Burial 6- 19

20. Undertaker Fred K Robinson
Address Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70960

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 82

112

2. FULL NAME Joseph Korn
(a) Residence No. 4 miles no. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Korn
6. DATE OF BIRTH (month, day and year): Sept 27 -
7. AGE: Years 62 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS
10. NAME OF FATHER: Frank Korn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Bohemia
12. MAIDEN NAME OF MOTHER: Anna Cyplak
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bohemia

14. Informant: Ben W Korn
(Address): Nampa Idaho
15. Filed 6-23, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 22 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to June 22, 1930
that I last saw him alive on June 22, 1930
and that death occurred, on the date stated above, at 8-a- m.
The CAUSE OF DEATH* was as follows: Acute Indigestion with shock with fatal effect on diseased heart.
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary): Chronic Calcified valves of left heart & aorta
..... (duration) 2 yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy showed only heart cond.
(Signed) J H Murray M. D.
June 25, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Catholic Cem. | Date of Burial: 6-25 1930
20. Undertaker: Fred K Robinson | Address: Nampa

Murray

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

County of Canyon

City of Rural

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 2006

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70961

Local Registrar's No. 81

129

2. FULL NAME Alice Belle Miller

(a) Residence. No. 12 Miles S. Nampa St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 19 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	7	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (Housewife)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Richard R. Stuckey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Mc Vicker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant U. G. Miller

(Address) Houston #2

15. Filed 6-25, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1930, to June 21, 1930

that I last saw her alive on June 21, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) O. C. Bellamy M. D.

6-25-1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	6-24 1930

20. Undertaker	Address
F. K. Robinson	Nampa Ida

B

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 70962

Local Registrar's No. 80

40

2. FULL NAME Cecil Blaine Vincent

(a) Residence. No. Rural St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) April, 13 1928

7. AGE: Years 1, Months 2, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER J.F. Vincent

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.

12. MAIDEN NAME OF MOTHER Tellie Acree

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J.F. Vincent

(Address) R# Nampa Idaho

15. Filed 6 - 26, 1930 Seitha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Saw the body after death had just occured June 21, 1930 to ..... 19..., that I last saw h..... alive on ..... and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows: Died in a spasm. No one knows the cause of the seizure. I did not see him until after death — Few minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None made

(Signed) J H Murray M. D.

June 26, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlown Cem.

Date of Burial: 6-23-30 19

20. Undertaker: F.K. Robinson

Address

RECEIVED JUL 5 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70963

County of Canyon Registration District No. .....
~~City of~~ Rural Primary Registration District No. ..... Local Registrar's No. 27
(No. ✓ .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** Richard J. Hyde
(a) Residence. No. 7 Miles S-W- Nampa St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 2/19/47

7. AGE: 83 Years | Months: 4 | Days: — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Geo. Hyde
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Mrs W. C. Bingham Kuna, Ida

15. Filed 6-22, 19.. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to May 15, 1930
that I last saw him alive on May 15, 1930
and that death occurred, on the date stated above, at 12 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis and Myocarditis
..... (duration) 6 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) H. P. Ross, M. D.
June 19, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: [illegible] | Date of Burial: 6-22 1930

20. Undertaker: F. K. Robinson | Address: Nampa

...ormation on this certificate is an exact COPY of the official certificate at place of death.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70964

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006 Local Registrar's No. 78
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME Ida Nettie Doll.
(a) Residence. No. 219 - 13th Ave. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~

6. DATE OF BIRTH (month, day and year) March 8th 1920

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
10	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Walla Walla Washington

PARENTS

10. NAME OF FATHER Claude Doll
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Florence Vernon
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Walla Walla Washington

14. Informant (Address) Mr. Claude Doll Nampa, Idaho

15. Filed 6-18, 1930 Bertha Carney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 17, 1930
that I last saw her alive on June 16, 1930
and that death occurred, on the date stated above, at 12.05 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fracture of Pelvis and internal injuries Shock Auto Accident
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 6-16-8 P.M.
Was there an autopsy? No
What test confirmed diagnosis? X Ray. Clinical
(Signed) V C Beelmap M. D.
6-18, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal Kohlerlawn - Nampa
Date of Burial 19

20. Undertaker Mrs. Nina M. Falley
Address Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70965

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Rural

Registration District No. 7
Primary Registration District No. 2006
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 77

2. FULL NAME Roswell Alonzo McKimmy

74a

(a) Residence. No. Melba Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1857-10-8.

7 AGE: 72 Years, Months 8, Days 6. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS
10 NAME OF FATHER: John McKimmy
11 BIRTHPLACE OF FATHER (city or town) (State or country): Iowa.
12 MAIDEN NAME OF MOTHER: Jane Woodside
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iowa.

14 Informant: Clarence McKimmy
(Address) Melba Ida.

15 Filed 6-18, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 14, 1930. (Month) (Day) 19.. (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to June 14, 1930, that I last saw him alive on June 5, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary): Arteriosclerosis
(duration) Several yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Bellman M. D.
6-18, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Melba Cem.
Date of Burial: 6-16-30 19..

20. Undertaker: F. K. Robinson
Address: Nampa Ida.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70966

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006
(No. Stanley Cabinet)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 76

161 (B

2. FULL NAME Infant Son of Mr. & Mrs. S. J. Moulton

(a) Residence. No. 908 - 11 Ave S. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: W.
5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 15 1930.

7 AGE — Years: — Months: — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nampa Ida

PARENTS
10 NAME OF FATHER S. J. Moulton
11 BIRTHPLACE OF FATHER (city or town) (State or country) S. D.
12 MAIDEN NAME OF MOTHER Elizabeth Thomas.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant S. J. Moulton
(Address) Nampa Idaho

15 Filed 6-15, 1930 Leela Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to June 14, 1930, that I last saw him alive on June 14, 1930, and that death occurred, on the date stated above, at 11 30 p m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage due to birth injuries
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lumbar Puncture
(Signed) Samuel A Swayne M. D.
19 (Address) June 21-30
Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: [illegible]
Date of Burial: 6-16 19

20. Undertaker: F. K. Robinson
Address: Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70967

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. Nampa 6
Local Registrar's No. 75
(No. Mercy Hospital) 33
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Edward Miller 65 & 67.

(a) Residence. No. Lone Star Road St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mary Ellen Miller

6. DATE OF BIRTH (month, day and year) February 15th 186[illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	3	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) self.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER George Miller.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Esther Reburn.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio.

14. Informant Mrs. Mary E. Miller
(Address) Nampa Idaho.

15. Filed 6-15, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1928, to June 12, 1930, that I last saw h[illegible] alive on June 12, 1930, and that death occurred, on the date stated above, at 1:10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestinal tuberculosis
(Hemorrhage)
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Tuberculous adenitis
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 6-6-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Reburn M. D.
6-14-, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 6-15 1930
20. Undertaker: Wm D. Talley — Address: Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70968

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. ____
Primary Registration District No. 3[illegible]
(No. Powell Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

47

2. FULL NAME Mary J. Ingram
(a) Residence. No. Powell Ave St. ____
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.M.
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Calvin Ingram

6. DATE OF BIRTH (month, day and year) June 10th 1843

7. AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
87	11	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10. NAME OF FATHER ____ Cole
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Lavina Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penna.

14. Informant (Address) Mrs Marlatt Nampa, Idaho

15. Filed ____, 19__ [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1926, to June 4, 1930
that I last saw her alive on June 3, 1930
and that death occurred, on the date stated above, at 3:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Breast
Involving Lung.

____ (duration) 6 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? yes Date of 1924
Was there an autopsy? no
What test confirmed diagnosis? ____
(Signed) V C Billings M. D.
June 5, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa
Date of Burial: 6-5 193[illegible]

20. Undertaker: Mrs Jina N. [illegible]
Address: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70969

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 73

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Besse W. Barth

(a) Residence. No. Nampa Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 3-25-30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	2	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Philadelphia.

PARENTS

10. NAME OF FATHER Samuel Weiss.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Kline

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Wm. Barth

(Address) Nampa Ida.

15. Filed 6-5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930 to June 1, 1930

that I last saw her alive on June 1, 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Injuries received in Auto wreck - 6 fractured ribs & internal hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) H. P. Ross M. D.

Jun 26, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	6-5-30 19

20. Undertaker	Address
F. K. Robinson	Nampa Ida.

FROM is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70971

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 71

PLACE OF DEATH

County of Canyon
City of Nampa
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mr. Cornelius Peter Jensma. 41

(a) Residence. No. 803 5th Ave. So. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Emma Dell Jensma

6. DATE OF BIRTH (month, day and year) June 13, 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52 yrs.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work President of Jensma Creamery.
(b) General nature of industry, business, or establishment in which employed (or employer) Jensma Creamery.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ten Boer, Holland.

PARENTS

10. NAME OF FATHER Mr. Peter Jensma.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Holland

14. Informant Mrs Emma Jensma.
(Address) Nampa Idaho

15. Filed 6-3, 1930 Leota Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to May 31, 1930
that I last saw h~~im~~ alive on May 31, 1930
and that death occurred, on the date stated above, at 5 m.
The CAUSE OF DEATH* was as follows:
Septicemia due to gas producing organisms following injection of hay fever Pollen Extract (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of May 30-31
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Samuel M Swayne M. D.
June 5, 1930 (Address) Samuel M Swayne M.D.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	6/3/1930
20. Undertaker	Address
F. K. Robinson	Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70972

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 30

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME William Patterson.

(a) Residence. No. 104-13th. ave. S. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9-27-1840

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	8	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Rachel Patterson.

(Address) Nampa Ida.

15. Filed 6-3, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to June 1, 1930
that I last saw him alive on May 29, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Williams M. D.

6-2-30, 19 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerdown Cem.	6/3/ 1930.

20. Undertaker	Address
F.K. Robinson	Nampa Ida.

V.C.B.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70973

PLACE OF DEATH

County of Canyon
City of Nampa.
Registration District No. 7
Primary Registration District No. 1606
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 69

101a

2. FULL NAME Ralph G. Madsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) May, 30 1900

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30		2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home- State School

(b) General nature of industry, business, or establishment in which employed (or employer) Moran 8-10 years.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gray Ida.

PARENTS

10. NAME OF FATHER John P. Madsen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Jenne Hanson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Jenne Hanson
(Address) Nampa Ida.

15. Filed 6-4, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to June 1, 1930
that I last saw him alive on June 1, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) J. F. Rodes, M. D.
June 2, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	6-4-1930

20. Undertaker	Address
F. K. Robinson	Nampa Ida

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70974

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ~~24~~ 7

74a

2. FULL NAME Clarence Kinsey Hanna.
(a) Residence. No. Parma St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 19 1865
7. AGE Years 65 Months 0 Days 11 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Orchardist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Mancato
(State or country) Minnesota

PARENTS
10. NAME OF FATHER Andrew Hanna
11. BIRTHPLACE OF FATHER (city or town) Reynoldsburg
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Emily Maxfield
13. BIRTHPLACE OF MOTHER (city or town) Etna
(State or Country) Ohio

14. Informant Belle Rooney
(Address) Parma Ida
15. Filed 7/1, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 30, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 12-30 P.m.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) D. Mitchell, M. D.
7/1, 1930 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Roswell
Date of Burial 7/2 1930
20. Undertaker C. V. Peckham
Address Caldwell Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70975

PLACE OF DEATH
County of Canyon
City of Parma
Registration District No.
Primary Registration District No. 2007
Local Registrar's No. 8

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME. David Andrew McCullough. 99B

(a) Residence. No. Parma #3 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 17 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranching
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant L D McCullough
(Address) Parma #3

15. Filed 7/1, 1930. Lulu C Waldorf Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to July 1, 1930
that I last saw him alive on June 25, 1930
and that death occurred, on the date stated above, at 11-30 m.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
Arterio-Sclerosis, Hypertension
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C M Tuttabell, M. D.
7/1, 1930 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
LaBelle Missouri	
20. Undertaker	Address
J. V. Peckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

PLACE OF DEATH

County of Canyon

City of Parma

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

DO NOT WRITE IN THIS SPACE

State File No. 70976

Local Registrar's No. 69

164

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John A. Boyd

(a) Residence. No. Parma Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1848

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
82			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Sterling Kentucky

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs M. J. Stiles

(Address) Parma Ida

15. Filed 6-12-, 1930. John L. Meyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

that I last saw h.... alive on ....., 19....

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Old Age. Natural death.
(Advice of County Physician.)

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Paul L. Case, M. D.
Coroner.

June 11-30 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	6-11 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida.

Jan 28-1930 June 10-

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70977

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 70
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah A. Milliner

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 21 1847

7. AGE Years 83 Months 11 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales

PARENTS
10. NAME OF FATHER Barter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Wm Milliner Caldwell Idaho

15. Filed 7-2- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11- 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 30 to June 10 1930
that I last saw her alive on June 10 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arthritis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) M. Kaley, M. D.
June 12, 1930 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal Canyon Hill Cemetery
Date of Burial June 14-30

20. Undertaker Paul L. Case
Address Caldwell Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70978

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 71
(No.) 161a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Tegnell
(a) Residence. No. 522 N Kimble St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) June 11-1930
7. AGE Years — Months — Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Caldwell Ida

PARENTS
10. NAME OF FATHER F. L. Tegnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Melva Graham
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oklahoma

14. Informant (Address) F. L. Tegnell Caldwell Ida
15. Filed 6-13- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 11 1930 to June 13 1930
that I last saw him alive on June 13 1930
and that death occurred, on the date stated above, at 2 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Too premature
(duration) yrs. mos. 1-2½ hrs
CONTRIBUTORY (Secondary) Premature
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C. R. Whittenberger M. D.
June 13 1930 (Address) Caldwell, Ida

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 6-13 1930
20. Undertaker C. V. Peckham
Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70979

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 . Local Registrar's No. 72
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

146

2. FULL NAME Ellen Charlotte Sheets
(a) Residence. No. R F D Caldwell Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 31, 1911

7. AGE: 19 Years | Months: 2 | Days: 16 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Houston, Idaho

PARENTS

10. NAME OF FATHER John F. Sheets
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey
12. MAIDEN NAME OF MOTHER Stella Doan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant (Address) John F. Sheets Caldwell Idaho

15. Filed 6-16-, 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to June 15, 1930
that I last saw her alive on June 14, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Septicemia result of
Miscarriage

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. N. Case, M. D.
6/16, 1930 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 6-16-30 19

20. Undertaker: Paul L. Case | Address: Caldwell

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70980

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 73
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161B

2. **FULL NAME** Baby Gollob

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	- -	- -		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell

PARENTS

10. NAME OF FATHER Martin P Gollob

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ethel Fuller

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Caldwell Ida

14. Informant G H Fuller
(Address) ~~Caldwell Idaho~~

15. Filed 6-17- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930 to June 16, 1930
that I last saw h.s alive on June 16 1930
and that death occurred, on the date stated above, at 8 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Instrumental Forces
Delivery During Birth

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Faulty Position + Prolonged
Labor (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? Yes Date of June 16-30
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E B Dreslin, M. D.
19 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	6-18-30 19
20. Undertaker	Address
Paul L. Case	Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70981

PLACE OF DEATH Canyon
County of Caldwell
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 74

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Mary Alice Wilson 74a

(a) Residence. No. 303 N Kimball St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sept 4 1854

6. DATE OF BIRTH (month, day and year): Sept 4 1854

7. AGE: Years 75 | Months 9 | Days 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Beverley West Virginia

PARENTS

10. NAME OF FATHER: Hugh Lee Hart
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: Rebecca Harper
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Not known

14. Informant (Address): Nell Wilson Caldwell Idaho

15. Filed 6-22-1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1930 to June 20 1930
that I last saw her alive on June 19 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C. W. Graham, M. D.
6-22-1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill. Date of Burial: 6/22 1930
20. Undertaker: E. V. Peckham Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70982

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 75
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Elizabeth Brewer
(a) Residence. No. Modesto Cal St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1 - 1866

7. AGE Years 64 Months 2 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennissee

PARENTS
10. NAME OF FATHER Ben Loyd.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennissee
12. MAIDEN NAME OF MOTHER Caroline Hankins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tennissee

14. Informant (Address) Janie Murphy Modesto California

15. Filed 6-25- 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19 to — 19
that I last saw h dead alive on June 21 1930
and that death occurred, on the date stated above, at 2.15a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
Apoplexy.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis & Nephritis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History of a former attack and appearance of body
(Signed) S. B. Dudley, M. D.
June 24, 1930 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal Parkio Missouri
Date of Burial 19

20. Undertaker C. V. Peckham
Address Caldwell Ida

Kaley

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70983

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 76
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry W. Y. Tschan
(a) Residence. No. Caldwell #2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. ~~Single, Married, Widowed, or Divorced~~ (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Tschan
6. DATE OF BIRTH (month, day and year) Sept 29 - '80
7. AGE Years 49 Months 8 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Calhoun Illinois

PARENTS
10. NAME OF FATHER Rudolph Tschan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Susan Richard
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Switzerland

14. Informant (Address) Mrs Henry Tschan

15. Filed 6-26 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1930 to June 22 1930
that I last saw him alive on June 22 1930
and that death occurred, on the date stated above, at 7-45 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis from pleuritic extension
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Flu
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date June 21-30
Was there an autopsy? No
What test confirmed diagnosis? operation
(Signed) J. M. Kaley, M. D.
6-23 1930 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial June 25 1930
20. Undertaker C. V. Peckham
Address Caldwell

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70984

PLACE OF DEATH
County of Canyon
City of Notus #1

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 44
(No. 189)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hezekiah L. McLaughlin
(a) Residence. No. Notus #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 9 1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Charles McLaughlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Rachel Carvill
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant (Address) M. W. McLaughlin Notus, Idaho R#1

15. Filed 7-5-, 1930 John S. Mayes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 12 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Kick of horse
Fracture chest over heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M. D.
, 19 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Greenleaf Cem. Date of Burial: 7/3 1930
20. Undertaker: C. N. Peckham Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70985

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 78
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Alexander Dement
(a) Residence, No. Caldwell R#1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Malinda C. Dement

6. DATE OF BIRTH (month, day and year) April 7 - 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72 - 82	2	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Quincy Illinois

PARENTS

10. NAME OF FATHER Benaja Dement
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Nancy A. Wardens
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant Mrs. W.E. Norton
(Address) Caldwell Ida

15. Filed 7-5-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June. 30, 1930, to July 1, 1930
that I last saw him alive on June. 30, 1930
and that death occurred, on the date stated above, at 10 15 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Coronary Compensation

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Myocarditis Broken Comp.
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? Clinical
(Signed) David E Brand M. D.
July 2, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	7 - 3 - 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 3

DO NOT WRITE IN THIS SPACE
State File No. 70986

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No.
Primary Registration District No. 1005
Local Registrar's No. 79
(No. 201)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laurie Samuel Manning

(a) Residence. No. St. Jordan Valley Oregon
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 20, 1903

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	5	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10. NAME OF FATHER O R Manning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Margaret Sarkkila
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Finland

14. Informant Fred Manning
(Address) Golden Gate Caldwell Idaho

15. Filed 7-5-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 3- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to July 3, 1930, that I last saw him alive on July 2, 1930, and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fracture 7 neck 4th Cervical (Accidental) - broke his neck diving in shallow water near Jordan Valley, Oregon (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [illegible], M. D.
7/5, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 7-6-1930
20. Undertaker: Paul L.Case — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 15 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

70986

Dr. F.M. Cole
Caldwell, Idaho

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Laurie Samuel Manning who died at Caldwell, Idaho on July 3, 1930
Cause of death given as "Fracture of neck 4th Cervical." Accidental

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE IT OCCURRED.

PLEASE ANSWER BELOW:

This man broke his neck diving in shallow water. The accident happened near Jordan Valley, Oregon.

(Signed) FM. Cole

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70987

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 9
Primary Registration District No. 1005
Local Registrar's No. 80
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Bill Momberg

(a) Residence. No. 9" & Fillmore St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

no

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13 1910

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Meat Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Cty Meat Market

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho

PARENTS

10. NAME OF FATHER J W Momberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mabel Hogan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) London England

14. Informant J W Momberg
(Address) Caldwell Ida

15. Filed 7-7-, 1930 John L. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1930, 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4:30 P. M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Revolver Shot thru head.
Suicide.
No Inquest.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L. Case, M. D.
July 7-30 19.... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	7-8-30 19
20. Undertaker	Address
Paul L.Case	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 20988

PLACE OF DEATH
County of Cassia
City of Albion

Registration District No. 119
Primary Registration District No. 2198
(No.) Local Registrar's No. 50
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Conrad Engel King

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If ~~married~~, widowed, ~~or divorced~~
HUSBAND of (or) ~~WIFE of~~ Sophia Engel King

6. DATE OF BIRTH (month, day and year) June 22-1842

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	4	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) F. E. Engel Ross

15. Filed July 1, 1930 C. L. Slater Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 4, 1930, that I last saw him alive on June 2, 1930, and that death occurred, on the date stated above, at 3:20 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) C. L. Slater, M. D.
July 1, 1930 (Address) Malta, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Idaho	June 7 1930
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

TRANSPORTATION OF CORPSE

(Always write with black ink)

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 20989

PLACE OF DEATH

County of Cassia Registration District No. 119

City of Malta Primary Registration District No. 2198 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Emma Lorine Smith

90

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 22 1922

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malta Ida.

PARENTS

10. NAME OF FATHER Samuel N Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Vena Osterhout

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Elba Idaho

14. Informant D. M. Smith
(Address) Malta Ida.

15. Filed July 1 1930 C. F. Sater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1929, to Mar 30, 1930
that I last saw her alive on Mar 30 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral regurgitation

.....

.....

.....(duration) 1 yrs. ..... mos. 15 ds.

CONTRIBUTORY None
(Secondary)

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Typical

(Signed) C. F. Sater M. D.
July 1, 1930 (Address) Malta Idaho

19. Place of Burial, Cremation, or Removal Malta — Date of Burial April 2 1930

20. Undertaker D. E. Johnson — Address Burley

Information on this certificate is an exact COPY of the official certificate at place of death.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70990

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Cassia
City of Sublett

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Hopewell

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	56	7		..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer Rail Road
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) England

PARENTS

10. NAME OF FATHER George Hopewell

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) England

12. MAIDEN NAME OF MOTHER Annie Groves

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) England

14. Informant Fannie H Benson
(Address) Lime Ore

15. Filed 6-2, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
..... (Month) ..... (Day) ....., 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....

(Signed) D E Johnson Co Coroner
June 2, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial June 2 1930

20. Undertaker D. E. JOHNSON — Address Burley

That the body ofthe deceased was found floating in Sublett Lake in Lake Canyon on May 31 1930; The the jury found the deceased came to his death from a gunshot wound in the left side of his neck, between the dates of May 26 and May 31, 1930, the shot comming from a source unknown.

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70991

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha J Haag

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carl G Haag

6. DATE OF BIRTH (month, day and year) Feb. 16 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	3	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Sweeden
(State or country)

PARENTS

10. NAME OF FATHER Eric Johanson

11. BIRTHPLACE OF FATHER (city or town) Sweeden
(State or Country)

12. MAIDEN NAME OF MOTHER Martha Olson

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Sweeden

14. Informant Esther Hedin
(Address) Burley Ida

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21 o 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to May 21, 1930
that I last saw h.. alive on May 21, 1930
and that death occurred, on the date stated above, at 3.15 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
Bilateral

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) A. Edward Fabyan M. D.
....., 19..... (Address) J Burley Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	May 26 1930
20. Undertaker	Address
D E Johnson	Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70992

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chancy Frost

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

10/a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of LaNeva Frost.

6. DATE OF BIRTH (month, day and year) Oct. 8, 1866

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	7	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Samuel B Frost
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jersey
12. MAIDEN NAME OF MOTHER Esther Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant .....
(Address) .....

15. Filed 6-20-, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 4, 1930, to May 14, 1930,
that I last saw h~~e~~ alive on May 13, 1930
and that death occurred, on the date stated above, at 9:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar Bilat
.....
.....
.....(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Edward Frazier, M. D.
....., 19..... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Heyburn Ida	
20. Undertaker W. E. Johnson	Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70993

PLACE OF DEATH
County of Cassia
City of Albion

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose Elizabeth Thompson

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James M Thompson

6. DATE OF BIRTH (month, day, and year) Dec 4 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	3	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10. NAME OF FATHER Leo W Butler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER Frances Bailey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant (Address) J M Thompson Albion Ida.

15. Filed 6-1-, 1930 F A Butler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to May 19, 1930, that I last saw her alive on May 19, 1930 and that death occurred, on the date stated above, at 9A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Autopsy

(Signed) F A Butler, M. D.
May 20, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida.	May 21 1930
20. Undertaker W E Johnson	Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70994

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Fred Schwartz

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 15, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	7	[illegible]	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10. NAME OF FATHER Fred Schwartz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Sarah Jane Killen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Mattie Glendinning Parma Ida

15. Filed 6-1-, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at 8:43 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
.....
.....
.....(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) D. E. Johnson Co Coroner M.D.
May 13, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	May 14 1930
20. Undertaker	Address
D. E. Johnson	Burley

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 70995

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. **FULL NAME** Rex Stafford

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. (Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 6 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	8	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Hamilton P Stafford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolyna
12. MAIDEN NAME OF MOTHER Annie Fairchilds
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wabash

14. Informant Annie Stafford
(Address) Burley Ida

15. Filed 6-1- A 30 F. A Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28, 1930, to May 3, 1930
that I last saw him alive on May 3, 1930
and that death occurred, on the date stated above, at 10:40 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Laboratory
(Signed) F. A Cutler, M. D.
May 5, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Burley Ida	
20. Undertaker D. E. Johnson	Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUN 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70996

PLACE OF DEATH

County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Barnard Jacobs

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 3 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs, or ..... min.
	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Declo Ida
(State or country)

PARENTS

10. NAME OF FATHER Rex H Jacobs.
11. BIRTHPLACE OF FATHER (city or town) Pleasant Green
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Clair McHale.
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Penn

14. Informant R. H. Jacobs.
(Address) Declo Ida.

15. Filed June 1, 1930 F. M. Corbett Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Suffocation
Accidental
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) D. E. Johnson Coroner M. D.
May 3, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Declo Ida	May 4 1930
20. Undertaker D. E. Johnson	Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 70997

PLACE OF DEATH

County of Clearwater

City of Elk River

Registration District No. 91

Primary Registration District No. 2168

Local Registrar's No. 8

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ezra E. Du Praw

(a) Residence. No. ..... St. 11a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Emma Rose Du Praw

6. DATE OF BIRTH (month, day and year): Jan. 2, 1874

7. AGE: Years 56 | Months 4 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Electrical Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber

(c) Name of employer: Potlatch Lumber Co.

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: Harvey Du Praw

11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14. Informant: Mrs. ~~Ezra~~ ~~[illegible]~~ Du Praw,
(Address) Elk River, Idaho

15. Filed June 20, 1930. Mildred Hambly. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 14, 1930

that I last saw him alive on May 13, 1930

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) O M Husted, M. D.

5/14, 1930 (Address) Elk River, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Idaho | Date of Burial: May 16 1930

20. Undertaker: H E Hunt | Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70998

PLACE OF DEATH

County of Clearwater

City of Elk River, Idaho

Registration District No. 91

Primary Registration District No. 2168

Local Registrar's No. 7

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME OLE KRAGNES.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 39 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Pottatch Lumber Co.,

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant .....
(Address)

15. Filed June 20, 1930 Mildred Hambly
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to April 2nd, 1930 that I last saw him alive on April 2nd, 1930 and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings

(Signed) O M Husted, M. D.

4/2, 1930 (Address) Elk River, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 70999

PLACE OF DEATH
County of Clearwater
City of Elk River

Registration District No. 91
Primary Registration District No. 2168
Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Langford Brown

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Child.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of child

6. DATE OF BIRTH (month, day and year) June 22 - 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Elk River, Id.

PARENTS

10. NAME OF FATHER Robert Kanode Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sundance Wyoming
12. MAIDEN NAME OF MOTHER Viola Speck.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant R. K. Brown
(Address) Elk River Ida

15. Filed July 1, 1930 Mildred Hambly Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 17, 1930
that I last saw him alive on June 17, 1930
and that death occurred, on the date stated above, at 11 55 a.m.

The CAUSE OF DEATH* was as follows:
Acute Tonsillitis - complicated by acute bi-lateral Otitis Media
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Septic Meningitis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory Findings

(Signed) O M Buzzard M. D.
6/17, 1930 (Address) Elk River, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Elk River, Ida.	June 18 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71000

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 47

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Leslie Lee Maitland

(a) Residence. No. Orofino Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. ~~1 yrs. 9 mos. 26 ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 1928

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None Baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Maries, Idaho

PARENTS

10. NAME OF FATHER James Allan Maitland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wallace Idaho
12. MAIDEN NAME OF MOTHER Helen Beulah Walbridge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Priest River Idaho

14. Informant Helen Beulah Bonner
(Address) Orofino

15. Filed 6/23, 19.... V. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to June 21, 1930
that I last saw him alive on June 21, 1930
and that death occurred, on the date stated above, at 5.40 P m.
The CAUSE OF DEATH* was as follows:
Lye burn of mouth, throat etc.

..... (duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) pneumonia

..... (duration) — yrs. — mos. 2 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A.B. Poppenhagen M. D.
June 23, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cook's Cemetery — Date of Burial: 6/23 19

20. Undertaker: V. A. Shaw — Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71001

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2154
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

2. FULL NAME Mildred Frenger,

(a) Residence. No. ..... St. Hope, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Frenger

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 52, Months 4, Days 26. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Bees, Cumberland, England.

PARENTS

10. NAME OF FATHER John Reay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Jane Shilton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Records: Northern Idaho Sanitarium, (Address) Orofino — Idaho.

15. Filed 6/16, 19.. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 1, 1930, to June 14, 1930 that I last saw her alive on June 13, 1930 and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis

..... (duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Psychosis with other somatic diseases (duration) ? yrs. 6 mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey M. D.

June 14, 1930 (Address) Orofino-Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: North Ida Sanitarium — Date of Burial 19

20. Undertaker: [signature] — Address: Orofino

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71002

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2157

Local Registrar's No. 45

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert G. Coffee. 129

(a) Residence. No. ..... St. Coeur d'Alene, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of Unascertained
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29, 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	1	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Illinois
(State or country)

PARENTS

10. NAME OF FATHER John Coffee

11. BIRTHPLACE OF FATHER (city or town) Illinois
(State or Country)

12. MAIDEN NAME OF MOTHER Helen Talbert

13. BIRTHPLACE OF MOTHER (city or town) Illinois
(State or Country)

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino — Idaho.

15. Filed 6/15, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1928, to June 11, 1930
that I last saw him alive on June 10, 1930
and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis -

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Paranoid Condition

(duration) 3 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey M. D.

June 11, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho San. Cemetery	June 12 1930
20. Undertaker	Address
F. A. Billberg - Hospital	Orofino - Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71003

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

181 B

2. FULL NAME Naomi Follett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F Follett

6. DATE OF BIRTH (month, day and year) Aug 20, 1843

7. AGE: Years 87 | Months [illegible] | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Id W. Follett
(Address) Orofino

15. Filed 6/9, 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1930, to June 8th, 1930
that I last saw her alive on 6 - 8 - , 1930
and that death occurred, on the date stated above, at 11:45 P m.
The CAUSE OF DEATH* was as follows:
Terminal Pneumonia
as above
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Crippled for years
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. F. Bohrtson, M. D.
6 - 9 - , 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gifford Idaho | Date of Burial: 6/[illegible] 19

20. Undertaker: W. D. Pinson | Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71004

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 20
Primary Registration District No. 2 1 7 4
Local Registrar's No. 47

(No.) 50-B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Jackson Space

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20 1930

7. AGE — Years | Months | Days: 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Orofino

PARENTS

10. NAME OF FATHER: M. D. Space
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wisp
12. MAIDEN NAME OF MOTHER: Ada A Ratliff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Craigmont

14. Informant: C. W. Space
(Address) Orofino

15. Filed 6/9, 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on May 26th, 1930
and that death occurred, on the date stated above, at night m.
The CAUSE OF DEATH* was as follows: (Not known by reality)

"Not known"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. H. Robinson, M. D.
6-8-, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilson — Date of Burial: June 9 1930

20. Undertaker: W. D. Simson — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71005

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2[illegible]

Local Registrar's No. 42

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Otto J. Lukenbill

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura A. Lukenbill

6. DATE OF BIRTH (month, day and year) May 21st 1884

7. AGE 46 Years 46 Months Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Clearwater T. Co

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grand Forks North Dakota

PARENTS

10. NAME OF FATHER Christian Lukenbill

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida N. Y.

12. MAIDEN NAME OF MOTHER Lois Becker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Laura Lukenbill
(Address) Ahsahka Ida

15. Filed 6/6, 1936 H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 3rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to May 28, 1930

that I last saw him alive on May 28, 1930

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart lesion

Years –

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Oedema & Dropsy

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? only Tapping – Date of Paracentesis

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Several

(Signed) W. F. Robertson (others) M. D.

6-6-, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Ida

Date of Burial 6/6 19

20. Undertaker W. D. Pinson

Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71006

PLACE OF DEATH

County of Custer
City of Near Mackay

CERTIFICATE OF DEATH

Registration District No. 76
Primary Registration District No. 2153 Local Registrar's No. 134
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edgar Ransom Ewing
(a) Residence. No. Mackay, Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE wt
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lila Edrington Ewing

6. DATE OF BIRTH (month, day and year) Oct 25 1883

7. AGE Years 47 Months ~~9~~ 8 Days ~~22~~ 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) ~~Houston, Idaho~~ Howard Kansas
(State or country)

PARENTS

10. NAME OF FATHER Reuben Henry Ewing
11. BIRTHPLACE OF FATHER (city or town) Lincoln Ill.
(State or Country)
12. MAIDEN NAME OF MOTHER Ruth Nichelson
13. BIRTHPLACE OF MOTHER (city or town) Michigan
(State or County)

14. Informant (Address) Harry Ewing Mackay, Idaho

15. Filed 7/7, 1930. Rose Nowacki Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) — 1 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30-30, 19....., to 7-1-30, 19.....
that I last saw him alive on 7-1-30, 19.....
and that death occurred, on the date stated above, at 8:10 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Carroll O. G. Jensen, M. D.
....., 19..... (Address) Mackay Ida.

19. Place of Burial, Cremation, or Removal Mt McCalif Mackay Idaho
Date of Burial July 3 1930

20. Undertaker Theo. R. Garnier
Address Mackay, Ida.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71008

PLACE OF DEATH
County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mary Ann Owens 178
(a) Residence. No. Glenns Ferry St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1-7-1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London England

PARENTS
10. NAME OF FATHER Joseph Edgley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary N Stillman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Joseph A. Owens
(Address) Glenns Ferry Ida

15. Filed 6-25, 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 22, 1930
that I last saw her alive on June 22, 1930
and that death occurred, on the date stated above, at 6 15 m.
The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Appendicitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Davis, M. D.
June 23, 1930 (Address) Glenns Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal	Date of Burial
Pocatello Idaho	June 26 1930

20. Undertaker S. C. Zacher Mt Home Ida Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71009

1 PLACE OF DEATH JUN 14 1930
County _____ State Idaho Registered No. _____
Township _____ or Village _____ or
City Mountain Home Idaho No. _____, _____ St., _____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

41

2 FULL NAME Sally Washington

(a) Residence. No. Owyhee Nevada St., _____ Ward. Owyhee Nevada
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Washington

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	69			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer

9 BIRTHPLACE (city or town) Owyhee Nevada
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Unknown

14 Informant Agency Records
(Address)

15 Filed June 20, 1930 Bessie M Lepper
State REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1929, to May 23 1929, 19____,
that I last saw her alive on May 23 1929, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Infection of Hand and arm

(duration) ____ yrs. ____ mos. 21 ds.

CONTRIBUTORY (SECONDARY) _____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Owyhee Nevada
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? _____

(Signed) _____, M. D.
, 19 (Address) Mountain Home Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Owyhee Nevada	May 26,1 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 26

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7101 0

PLACE OF DEATH

County of Franklin
City of Clifton

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 53

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Fanellyn Rice

(a) Residence. No. Clifton Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillie Hall Rice

6. DATE OF BIRTH (month, day and year) Mar 21 1877

7. AGE Years	Months	Days	If LESS than 1 day,
53	2	21	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Farmington Utah
(State or country)

PARENTS

10. NAME OF FATHER Wm. Rice

11. BIRTHPLACE OF FATHER (city or town) New York
(State or Country)

12. MAIDEN NAME OF MOTHER Anna Rose

13. BIRTHPLACE OF MOTHER (city or town) New York
(State or Country)

14. Informant Mrs Lillie Rice
(Address) Clifton Idaho

15. Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
He was struck by derrick accidentally & killed instantly

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓ Coroner

(Signed) M. Hennessy M.D.

6/14/ 1930 (Address) Franklin Co
Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Farmington Utah	June 16 30
20. Undertaker	**Address**
M. W. Hendreicks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Franklin State IDAHO Registered No. 71010
Township ____ or Village ____ or
City Clifton No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Fanellyn Rice
(a) Residence. No. Clifton, Idaho St., ____ Ward. ____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	M

5A IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6 DATE OF BIRTH (month, day, and year) Mar. 21, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	53	2	21	

8 OCCUPATION OF DECEASED
(a) Trade profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country) Utah

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) New York
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 INFORMANT ____
(Address)

15 FILED ____, 19____ REGISTRAR.

11—3184 U. S. GOVERNMENT PRINTING OFFICE: 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1930

17 I HEREBY CERTIFY, THAT I ATTENDED DECEASED FROM ____, 19____, TO ____, 19____,
THAT I LAST SAW H____ ALIVE ON ____, 19____,
AND THAT DEATH OCCURRED, ON THE DATE STATED ABOVE, AT ____ M.
THE CAUSE OF DEATH* WAS AS FOLLOWS:

He was struck by derrick accidently
and killed instantly

____ (DURATION) ____ YRS. ____ MOS. ____ DS.
CONTRIBUTORY ____
(SECONDARY)
____ (DURATION) ____ YRS. ____ MOS. ____ DS.

18 WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? ____
DID AN OPERATION PRECEDE DEATH? No DATE OF ____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? ____

(Signed) M. Hancey Coroner, M. D.,
,19 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL ____, 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209d
V. S. No. 98

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71011

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 52

129

2. FULL NAME Cora Elizabeth Amos

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25 1919

7. AGE	Years	Months	Days	If LESS than 1 day,
	11	11	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Idaho

PARENTS

10. NAME OF FATHER Wm. G Amos

11. BIRTHPLACE OF FATHER (city or town) (State or Country) IOWA

12. MAIDEN NAME OF MOTHER Bessie Plog

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ILLINOIS

14. Informant Wm. G. Amos
(Address) Preston Idaho

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3, 1929, to June 8, 1930
that I last saw her alive on June 8, 1930
and that death occurred, on the date stated above, at 7.45 p m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Rheumatic Endocarditis

(duration) — yrs. 9 mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.
June 9, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Idaho	June 10. 1930

20. Undertaker	Address
M. W. Hendricks	Preston

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71012

PLACE OF DEATH

County of Fremont
City of Ashton

Registration District No. Lo2
Primary Registration District No. 6

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Martha Vernette Courtney

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 14 1853

7. AGE	Years	Months	Days	If Less than 1 day, hrs. or min.
	76	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER William Elloit.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Matilda. Saltsman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Otto Sturm
(Address) Ashton Idaho

15. Filed 5-4, 1930 C. C. Meacham Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May April 1st 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26-, 1930, to 5-1, 1930
that I last saw h~~er~~ alive on 5-1-, 1930
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Mitral & Aortic Valve disease.
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) H.B.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? none.
(Signed) C. C. Meacham, M. D.
5-4, 1930 (Address) Ashton, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho
Date of Burial: 5/4/30 19
20. Undertaker: Lewis Kiser Ashton Idaho
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71013

PLACE OF DEATH

County of Fremont

City of Ashton.

Registration District No. 102

Primary Registration District No. 6

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Mrs J.A. George.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 14th 1868

7. AGE Years 61 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Thomas Humble

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Elmer George
(Address) Ashton Idaho

15. Filed 6-18-, 1930 A.C. Meacham Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930 to June 15, 1930

that I last saw her alive on June 15, 1930

and that death occurred, on the date stated above, at 9 A.M m.

The CAUSE OF DEATH* was as follows:

Gangrene of back due to Carbuncles.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. L. Harris M. D.

6-15-, 1930 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ashton Idaho — Date of Burial: 6/18/30 19

20. Undertaker: Lewis Kiser — Address: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71014

PLACE OF DEATH
County of Fremont
City of St. Anthony, Idaho
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 339
(No. 440)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathan Barrett
(a) Residence. No. St. Anthony Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 24th, 1844

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10. NAME OF FATHER Nathan T. Barrett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Keeler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Don Barrett
(Address) St. Anthony, Idaho.

15. Filed June 30th 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June 28, 1930
that I last saw him alive on June 28, 1930
and that death occurred, on the date stated above, at 9 1/2 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Accidental Fracture Ribs
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Heart + Rib
(Signed) P. M. Keeler, M. D.
6-28-, 1930 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Provo, Utah	July 2nd, 1930

20. Undertaker W. M. Hansen Address St. Anthony, Idaho.

SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71015

PLACE OF DEATH

County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 338

101a

2. FULL NAME Vera Elizabeth Davis

(a) Residence. No. St. Anthony, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~XXXXXXXX~~ Jed Davis
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 3rd, 1903

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	10	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER Frank D. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Rosana Gallaway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant G. R. Davis
(Address) St. Anthony Idaho Route # 1

15. Filed June 21st, 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21st, 1930 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6 - 14, 1930, to 6-21, 1930
that I last saw her alive on 6 - 21, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. D. Wright, M. D.
June 21st, 1930 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford
Date of Burial: June 24-1930

20. Undertaker: St. Anthony, Idaho.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7016

PLACE OF DEATH

County of Fremont

City of St. Anthony

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Celia Marinda Sadorus

(a) Residence. No. St. Anthony, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. m

(If nonresident give city or town a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If ~~married, widowed, or divorced~~
~~HUSBAND~~ of
(or) WIFE of Samuel S. Sadorus

6. DATE OF BIRTH (month, day and year) August 27th, 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	9	23	....hrs. or ....min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS

10. NAME OF FATHER James Whitaker

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Nancy Woodland

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) America

14. Informant Milinda Bowman
(Address) St. Anthony, Idaho

15. Filed June 21st, 1930 H. M. Hauser Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20th, 1930
(Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from ... 19.. to ... 10 Hrs
that I last saw h... alive on ... 20 ... 5-5
and that death occurred, on the date stated above, at ...

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

10 D 12
(duration) ... yrs. ... m

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... m

18. Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) C. Hewitt M.D.

June 21st, 1930 (Address) St. Anthony

*State the DISEASE CAUSING DEATH, or in deaths from ... CAUSES, state (1) MEANS AND NATURE OF INJUR... whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ora Cemetery | Date of B... June 22...

20. Undertaker: H. M. Hauser | Address St. Anthony, Ida...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED JUN 23 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Fremont

City of Egin

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

State File No. 71017

Local Registrar's No. 336

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriett Vilote Beck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan. (Month) 19 (Day) 1875 (Year)

7. AGE: 55 Yrs. 4 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Pleasant Grove Idaho

10. NAME OF Father: John Long

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: Emma Baker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Leah Jensen

(Address) St. Anthony Idaho Route 3

15. Filed June 4th 1930 W. W. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

89

16. DATE OF DEATH: June (Month) 2nd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1930, to 6 - 2 1930 that I last saw her alive on 6 - 2 1930, and that death occurred on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 6 hours mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. B. Wit M. D.

6/2 1930 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis Idaho

DATE OF BURIAL: June 6 - 1930

20. UNDERTAKER: W. M. Hansen

ADDRESS: St. Anthony Idaho

FORM V. S. No. 6-36-M-1-19

RECEIVED JUN 23 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7018

Registered No. 335

1. PLACE OF DEATH

County of Fremont

City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carlyle Ray White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April 25th 1925 (Month) (Day) (Year)

7. AGE: 5 Yrs. 1 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Anthony

10. NAME OF FATHER John M. White

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Mary Ann Husband.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John M. White

(Address) St Anthony

15. Filed June 2 1930 W. M. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

1000

16. DATE OF DEATH: June (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20th 1930, to June 1 1930, that I last saw him alive on May 31 1930, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. M. Keeler M. D.

6-1-1930. (Address) St. Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery — DATE OF BURIAL: June 2 1930

20. UNDERTAKER: Evans Funeral — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A-25M-1-19 RECEIVED JUN 23 1930 **CERTIFICATE OF DEATH**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71019
Local Registrar's No. 334

1. PLACE OF DEATH

County of Fremont
City of St. Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Clifford Wadsworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	married

6. DATE OF BIRTH Feb. (Month) 15 (Day) 1880 (Year)

7. AGE 50 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF Father Freeman Wadsworth

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Mary Branch

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lily Wadsworth
(Address) St. Anthony Route 3 Idaho

15. Filed June 1st 1930 W. W. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930 to May 31 1930, that I last saw him alive on May 31, 1930 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Addisons Disease

Probable (Duration) ..... yrs. 3 mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. M. Kelly M. D.
5-31-1930 (Address) St Anthony, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Ashton Idaho | **DATE OF BURIAL** June 3rd 1930

20. UNDERTAKER W. W. Hansen | **ADDRESS** St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 25 M. 1-19.

RECEIVED JUN 23 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Fremont
County of
City of Wilford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177
(No. , St.)

File No. 21030
Registered No. 333

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Klein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
July 22 (Month) (Day) 1857 (Year)

7. AGE
72
72 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): N

9. BIRTHPLACE
(State or Country) Not Known

10. NAME OF FATHER
Adam Klein

11. BIRTHPLACE OF FATHER
(State or Country) Not Known

12. MAIDEN NAME OF MOTHER
Frank Ru.

13. BIRTHPLACE OF MOTHER
Not Known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Klein
(Address) St Anthony Idaho R.D.I.

15. Filed May 22 1930 O M Hansen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 20th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1930, to May 1930, that I last saw h alive on 1930, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Old age)

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H B Rigby M. D.
May 21 1930 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilford. Ida.	May 23 1930
20. UNDERTAKER	ADDRESS
Thos J. Keller	Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71021

PLACE OF DEATH
County of Fremont
City of Egin

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 332

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

100A

2. FULL NAME Gale Mars Bradshaw

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 16-1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Egin Idaho

PARENTS

10. NAME OF FATHER George Bradshaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alma Nyo
12. MAIDEN NAME OF MOTHER Jennie Weaver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Egin Idaho

14. Informant George Bradshaw
(Address) St. Anthony Idaho Route 3

15. Filed May 8, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15-, 1930, to May 7, 1930
that I last saw her alive on May 7, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia (duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Whooping-Cough. (duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? L
Did an operation precede death? No Date of L
Was there an autopsy? No
What test confirmed diagnosis? Findings
(Signed) O. Ira Keller, M. D.
May 7, 1930 (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker	May 9- 1930

20. Undertaker W. M. Hansen Address St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71022

PLACE OF DEATH
County of Fremont
City of Twin Groves

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 331

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Charles How Law

(a) Residence. No. St. Anthony Idaho Route #2 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 23-1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	5	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arlenes Ohio

PARENTS

10. NAME OF FATHER Uriah Law
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Lulzina Anna Bird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Floyd Law
(Address) St Anthony Idaho Route 2

15. Filed May 1, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to May 1, 1930
that I last saw him alive on May 1, 1930
and that death occurred, on the date stated above, at 12 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? not known
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Urine & heart

(Signed) P. M. Keller, M. D.
5—1—, 1930 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Milford	May 4 1930
20. Undertaker	Address
W. M. Hansen	St. Anthony

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71023

PLACE OF DEATH
County of Fremont
City of St Anthony Idaho
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 330

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred O. Taylor

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Sarah Taylor

6. DATE OF BIRTH (month, day and year) April 26 1869

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucland Idaho

PARENTS
10. NAME OF FATHER John Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs Fred O. Taylor
(Address) St Anthony Idaho

15. Filed April 26, 1930 O M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 2nd, 1930, to Apr. 26, 1930
that I last saw him alive on Apr. 26, 1930
and that death occurred, on the date stated above, at 6:15 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Brights.
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) P. M. Kelly, M. D.
Apr. 26, 1930 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Anthony	Apr. 28 1930
20. Undertaker	Address
O M Hansen	St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71024

PLACE OF DEATH
County of Fremont
City of Parker

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 329

183

2. FULL NAME George Murry Ferrell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24 - 1873

7. AGE: Years 56, Months 8, Days 14. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Park County Montana

PARENTS
10. NAME OF FATHER: James A. Ferrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Rhoda Givens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo.

14. Informant: Maude Rodman
(Address) Pocatello Idaho

15. Filed April 8, 1930 O. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 7, 1930, to ——, 19..., that I last saw him alive on not at all, 19..., and that death occurred, on the date stated above, at about 9 a m.

The CAUSE OF DEATH* was as follows: Shotgun wound of chest probably suicidal - may have been accidental.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) T. A. Ellison, M. D.
Apr. 17, 1930 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview Cemetery
Date of Burial: Apr. 11 - 1930

20. Undertaker: O. M. Hansen
Address: St. Anthony Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71025

PLACE OF DEATH

County of Ada

City of Emmett

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Bemus

95

(a) Residence. No. 9 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 26 - 1864

7. AGE Years 66 Months 3 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Mrs. Lee Murray
(Address) Sweet Idaho

15. Filed 6/7, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 6, 1930

that I last saw him alive on June 2, 1930

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary hemorrhage
Severe hemorrhage June 2
Fatal hemorrhage June 6
none in between (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
Probably (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) [illegible], M. D.

6/7, 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brownlee Idaho

Date of Burial: 6/8 1930

20. Undertaker: C D Bucknum

Address: Emmett Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
RECEIVED JUL 5 1930

County of Ada
City of Emmett

Registration District No. 6
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 71026

Local Registrar's No.

74A

2. FULL NAME William Henry Nicklene

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 2-1856

7. AGE — Years: 74 — Months: 2 — Days: 7 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Holland Nicklene
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Jane Lambert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Mrs Ward Hall
(Address) Emmett Idaho

15. Filed 6/10, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8, 1930, to June 9, 1930
that I last saw him alive on June 9, 1930
and that death occurred, on the date stated above, at 7 a m.
The CAUSE OF DEATH* was as follows:
Apoplexia -
(duration) 12 hours yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J L Reynolds, M. D.
6/10, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 6/11 1930
20. Undertaker: C W Bucknum — Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21

Primary Registration District No.

File No. 71027

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaiah Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Oct (Month) 31 (Day) 1836 (Year)

7. AGE: 93 Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Aged
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: [illegible] Smith

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. E. Black
(Address)

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19, to aged 19,
that I last saw h alive on 19,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Not ill – He seemed to go to sleep & never woke
(Duration) Yrs. mos. ds.
Contributory (Secondary) Not Known by physician
(Duration) yrs. mos. ds.
(Signed) R. L. Greene M. D.
Jan 21 1930 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: a V Smith | DATE OF BURIAL: January 22 1930

20. UNDERTAKER: a V Smith & Son | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUL 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. ..... St.)

File No. 71028

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. McCarty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 9 (Day) 1867 (Year)

7. AGE: 63 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: David McCarty

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Phillips

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary McCarty

(Address) Hagerman

15. Filed June 11 1930

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1930, to June 10 1930, that I last saw him alive on June 1 1930, and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ~~6~~ Yrs. ..... mos. 5 ds.

Contributory (Secondary) Arterio Scherosis with high blood pressure

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) R H Greene M. D.

June 11 1930 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL 19

20. UNDERTAKER: L G John 2 M

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. ..... St.)

File No. 71029

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Abernathy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: not known (Month) (Day) 1 (Year)

7. AGE: about 40 Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed May 12, 1930

R H Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

204

16. DATE OF DEATH: May (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Was found dead — Organic Heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) perhaps acute indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Greene MD ~~M. D.~~

May 12 1930 (Address) Hagerman Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Rochester Minn

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: N E Thompson

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. , St.)

File No. 71030

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Jane Black

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1843 (Year)

7. AGE: 86 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Alexander Gibson

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Alvina Douglas

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel A. Block

(Address) Bliss Idaho

15. Filed June 17 1930

R H Greene MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Had no physician 19 ..., that I last saw h..... alive on ..... 19 ..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Aged

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Greene MD ~~M. D.~~

June 17 1930 (Address) Hagerman Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding Idaho

DATE OF BURIAL: Jun 18 1930

20. UNDERTAKER: A. G. Hawkins

ADDRESS: Gooding Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH JUL 2 1930

Registration District No. 21

County of Gooding

Primary Registration District No.

File No. 71031

City of Hagerman

(No. ..... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Adolph Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1897 (Year)

7. AGE: 33 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Gus Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Tessa Schillings

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Starry

(Address) Hagerman

15. Filed Mar 28 1930 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1930 to Mar 28 1930 that I last saw h[illegible] alive on Mar 28 1930 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Greene M. D.

Mar 28 1930 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iowa Johnson

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71035

PLACE OF DEATH
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No.) 161a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Beulah Jean Sink

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ✓
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1-7-30

7. AGE Years Months Days If LESS than 1 day, Six hrs. or min.

8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kamiah Ida
(State or country)

PARENTS
10. NAME OF FATHER Chas Sink
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Mae Davidson
13. BIRTHPLACE OF MOTHER (city or town) Wash
(State or Country)

14. Informant C R Sink
(Address)

15. Filed 6/25, 1930 J W Robertson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29 7 1929
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th, 1929, to July 29th, 1929
that I last saw her alive on July 29th, 1929
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature
8 mo

(duration) yrs. mos. ds.
CONTRIBUTORY Mother Decedent
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [illegible], M. D.
July 30, 1929 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Winona
Date of Burial 7/1 1930

20. Undertaker Kamiah Funeral Home
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71036

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101a

2. FULL NAME Abel Newton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie Thompson Newton

6. DATE OF BIRTH (month, day and year) 1864 about

7. AGE 66 about Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Nez Perce Reservation
(State or country) Idaho

PARENTS

10. NAME OF FATHER Pa-lee-ya-wash-kin

11. BIRTHPLACE OF FATHER (city or town) Not known
(State or Country)

12. MAIDEN NAME OF MOTHER Emma Newton

13. BIRTHPLACE OF MOTHER (city or town) Not known
(State or Country)

14. Informant Susie Minnie Newton
(Address)

15. Filed 7/26, 1930 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7th, 1930, to Above, 19..., that I last saw him alive on January 16th, 1930 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? very

(Signed) [illegible], M. D.

1/18, 1930 (Address) Kamiah,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah
Date of Burial 1-19 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71037

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miller John F

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Miller

6. DATE OF BIRTH (month, day and year) 5-9-1847

7. AGE ~~82~~ Years 82 Months 8 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER John F. Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Ohio~~ Germany
12. MAIDEN NAME OF MOTHER King
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant W B Kriebel
(Address)

15. Filed 7/2/, 1930 J H Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1st, 1929, to about 19
that I last saw him alive on January 31st, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Parkinson's Disease
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
7/2, 1930 (Address) Kamiah, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cragmont
Date of Burial 7/3/ 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71038

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

74a

2. FULL NAME Reed - Geo K.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mona Reed

6. DATE OF BIRTH (month, day and year) Aug-13-18X

7. AGE 87 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER James Reed
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Frank J. Reed
(Address)

15. Filed 7/26/, 1930 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to Aug, 19..., that I last saw him alive on Feb. 8th, 1930 and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

sudden
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) 1 Arrivan attack March 15-29
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [signature], M. D.
2/9, 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah | Date of Burial 7/10 1930

20. Undertaker Kamiah Funeral Home | Address Kamiah

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71039

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mae Sink

(a) Residence. No. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ F
4. COLOR OR RACE White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas. Sink

6. DATE OF BIRTH (month, day and year) Feb. 28-1888

7. AGE Years 41 Months 11 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton Wash

PARENTS
10. NAME OF FATHER Davidson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va. F
12. MAIDEN NAME OF MOTHER Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant Chas Sink
(Address)

15. Filed 7/26, 1930 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1929, to above, 19
that I last saw her alive on Feb. 11th, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Hemiplegia
(duration) yrs. 5 mos. ds.
CONTRIBUTORY (Secondary) Pregnancy
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
7/12, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Winona
Date of Burial 7/13 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71043

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 4
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Rebecca Norton Blackeagle

(a) Residence. No. ..... St. 1' (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Parsons

6. DATE OF BIRTH (month, day and year)

7. AGE 46 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kamiah - Idaho

PARENTS

10. NAME OF FATHER James Norton Blackeagle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER (Ah la lim ya we nun ny)
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Fanny M. Parsons
(Address) Kamiah Ida

15. Filed 6/26, 1930. J. O. Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 10, 1930
that I last saw her alive on March 10, 1930
and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. M. Verbeekuns M. D.
March 10, 1930 (Address) Koorkia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah Ind No 2 | Date of Burial 6/12 1930

20. Undertaker Kamiah Funeral Home | Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71044

PLACE OF DEATH
County of Kootenai
City of Kamiah
Registration District No. 49
Primary Registration District No. 2129
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

101A

2. FULL NAME Lenford W. Shaw.
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Ezzell K

6. DATE OF BIRTH (month, day and year) 10-28-1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72	72	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Horatio Shaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U.S.A.
12. MAIDEN NAME OF MOTHER Rose Grimes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U.S.A.

14. Informant Vera Shaw Thomasson
(Address) Ye Cramps Idy

15. Filed 6/26/30 J. A. Nickelson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 9th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6th 1930, to April 9th 1930
that I last saw her alive on April 9th 1930
and that death occurred, on the date stated above, at 11:30 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
April 10th 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah	7/10 1930
20. Undertaker Kamiah Funeral Home	Address Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71046

PLACE OF DEATH
County of Idaho
City of Cottonwood

Registration District No. 105
Primary Registration District No. 2183
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6

100a

2. FULL NAME Helene C. Eckermann

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: H. G. Eckermann

6. DATE OF BIRTH (month, day and year)

7. AGE: 68 Years | Months: 2 | Days: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Davenport Iowa

PARENTS

10. NAME OF FATHER: Hans. Rave.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Andge Peters
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Ed. Eckermann
(Address) Cottonwood Idaho

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1930, to June 3, 1930
that I last saw her alive on June 3d, 1930
and that death occurred, on the date stated above, at 8 45 P.m.
The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Cholecystitis
..... (duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. D. Shimick M. D.
June 4, 1930 (Address) Grangeville, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cottonwood Idaho | Date of Burial: 6-6 1930

20. Undertaker: Brawer-Wann | Address: Lewiston Ida

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 3183
File No. 71047
Registered No. 7

1. PLACE OF DEATH
County of Idaho
City of Cottonwood
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Albers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: January (Month) 29 (Day) 1859 (Year)

7. AGE: 71 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gittenburg Iowa

10. NAME OF FATHER: Wm Stamm

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Frida Haecher

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bob Albers
(Address) Chewelah Wn

15. Filed 6/10 1930 H. F. Ord D.C.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1928, to June 8th 1930 that I last saw h.. alive on June 7th 1930, and that death occurred on the date stated above, at 3:15 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) about Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. A. Woodcock M. D.
6-10 1930 (Address) Cottonwood, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood | DATE OF BURIAL: June 11 1930

20. UNDERTAKER: Beaver Mann | ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Green Creek

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... , ... St.)

File No. 71048

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adolph Ahlers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1898 (Year)

7. AGE: 32 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Teutopalis, Illinois

10. NAME OF FATHER: Joseph Ahlers

11. BIRTHPLACE OF FATHER (State or Country): St. Henry, Ohio

12. MAIDEN NAME OF MOTHER: Katherine Beckman

13. BIRTHPLACE OF MOTHER (State or Country): St. Henry, Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tony Wessels

(Address) Green Creek, Idaho.

15. Filed 6/11 1930 W. F. Orr per J.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1930 (Year) 1840

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19..., that I last saw h..... alive on ✓ 19..., and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Accidental - Fordson Tractor turned over, crushing chest.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

6/11 1930 (Address) Cottonwood

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Green Creek, Idaho

DATE OF BURIAL: 6/12 1930

20. UNDERTAKER: Vassar Und. Co.

ADDRESS: Lewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Ferdinand

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 7149

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Gerdes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Widowed

6. DATE OF BIRTH: Feb. (Month) 13 (Day) 1852 (Year)

7. AGE: 78 Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Hand

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Henry Gerdes

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Phebe Ann Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ally Wilson

(Address) Ferdinand Ida.

15. Filed 6/12 1930 W. F. Orr Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1930, to June 11 1930, that I last saw him alive on June 8 1930, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

6/12 1930 (Address) Tetonia Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Ida. DATE OF BURIAL: June 13 1930

20. UNDERTAKER: Vasser & Lewiston ADDRESS: Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible] RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Kenterville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... , ... St.)

File No. 71050

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Clara Frei

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 1 (Day) 1929 (Year)

7. AGE: ✓ Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kenterville, Idaho.

10. NAME OF FATHER Eusibius Frei

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Clara Ben Knecht

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eusibius Frei

(Address) Kenterville Idaho

15. Filed 6/24 1930 W. F. Orr I. C. Local Registrar

MEDICAL CERTIFICATE OF DEATH

159 B

16. DATE OF DEATH: June (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1930, to June 22 1930 that I last saw her alive on June 20 1930 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Congenital heart.
Patent Ductus arteriosus

(Duration) Yrs. 9 mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wesley F. Orr M. D.

6/23 1930 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kenterville, Idaho

DATE OF BURIAL: 6/23 1930

20. UNDERTAKER: Father Martin Kenterville

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. C. M. Cline

RECEIVED JUN 20 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71051

County of Jefferson
City of Milo

Registration District No. 73
Primary Registration District No. 214-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 86

44 B

2. FULL NAME Sarah Storer

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 19 1850

7. AGE: 80 Years | Months: 1 | Days: 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Wm Jackson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant F J Storer
(Address) Rigby #2

15. Filed May 1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15, 1930, to May 1, 1930
that I last saw her alive on June, 1927
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rigby #2
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [signature], M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rose Hill Cemetery Idaho Falls Ida. | Date of Burial: May 5 1930

20. Undertaker: Ivan J Keller | Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71052

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21V-0
Local Registrar's No. 47
(No. L. D. S. Hospital) 24
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lessie Lorenzo Cleverly

(a) Residence. No. ..... St. Shelton, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 29, 1914

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	0	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Shelton Idaho
(State or country)

PARENTS

10. NAME OF FATHER William J. Cleverly
11. BIRTHPLACE OF FATHER (city or town) Salt Lake City
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Emily L. Harmon
13. BIRTHPLACE OF MOTHER (city or town) Hartsville
(State or Country) Utah

14. Informant Mrs. Emily L. Harmon
(Address) Shelton, Idaho Rigby R. 6

15. Filed May 6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/ 1, 1930, to May 2, 1930
that I last saw him alive on May 2, 1930
and that death occurred, on the date stated above, at 2:10 A m.
The CAUSE OF DEATH* was as follows:
Epidemic Meningitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rigby, Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
5/7, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Shelton	May 6 1930

20. Undertaker	Address
Jack A. Hood	Idaho Falls

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71053

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2110
Local Registrar's No. 88
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME R. A. Stewart

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town an...
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos...

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5 1900

7. AGE: Years 29. Months 7 Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft Collins Colo.

PARENTS

10. NAME OF FATHER J. C. Wideman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y. State

14. Informant J. C. Wideman
(Address) Firth Idaho.

15. Filed May 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 4 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30, 1930, to May 4
that I last saw her alive on .....
and that death occurred, on the date stated above, at .....
The CAUSE OF DEATH* was as follows: General peritonitis
..... (duration) ..... yrs. ..... mo...
CONTRIBUTORY (Secondary) Pyosalphinx ruptured ovarian ...
..... (duration) ..... yrs. ..... mo...

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) F. E. Roberts
May 4, 1930 (Address) Shelley

*State the DISEASE CAUSING DEATH, or in deaths from CAUSES, state (1) MEANS AND NATURE OF INJUR... whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of ... 5/...

20. Undertaker: V. F. McHan Address: Ida...

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71054

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214-0

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

41

2. FULL NAME Roy Victor Jones

(a) Residence. No. ..... St. Asgood

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 25

7. AGE — Years: 11 | Months: 5 | Days: 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS

10. NAME OF FATHER: John William Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Florence E. Chissold

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: John William Jones

(Address) Idaho Falls Rt # 7

15. Filed May 6, 1930 (Signature) Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to May 4, 1930

that I last saw him alive on May 3, 1930

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(Streptococcus)

(duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) A. P. Sodenquist, M. D.

4/8, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Iron	May 7 1930
20. Undertaker: Jack A. Hood	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71055

Registration District No. 73
Primary Registration District No. 214-0
Local Registrar's No. 90

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Asa Harrington Bartlett

(a) Residence. No. ..... St. Roberts, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annie Bartlett
6. DATE OF BIRTH (month, day and year): April 16, 1852
7. AGE: Years 78 | Months 0 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Maine

PARENTS
10. NAME OF FATHER: Enoch Bartlett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant: Mrs Colores Moss
(Address) Midas, Nevada
15. Filed May 21, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 25, 1930, to May 1, 1930
that I last saw him alive on May 1, 1930
and that death occurred, on the date stated above, at 12-10 P m.
The CAUSE OF DEATH* was as follows:
Cystitis & Pyelitis Caused
from Enlarged Prostate
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) H. D. Spencer, M. D.
May 7, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Annis	May 4 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71056

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 3
Primary Registration District No. 210-0
Local Registrar's No. 91

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Marvan Williams

(a) Residence. No. 776 - 2 St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 17-1929

7. AGE

Years	Months	Days	If LESS than 1 day,
1	2	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Ron Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Livermore Colo.
12. MAIDEN NAME OF MOTHER Harriett Ball
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iona Ida

14. Informant Ron Williams
(Address) Idaho Falls Ida.

15. Filed May 8, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to May 7, 1930
that I last saw her alive on May 7, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cold.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
5/8/30 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal Iona Cemetery Date of Burial May 9 1930.

20. Undertaker F. F. McKean Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

57

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71057

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 2150
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

100a

2. FULL NAME Herman C Schrank
(a) Residence. No. Eagle Rock St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Schrank

6. DATE OF BIRTH (month, day and year) Not Known.

7. AGE Years 57 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Arthur W. Schrank
(Address) American Falls Idaho

15. Filed May 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to May 9, 1930
that I last saw him alive on May 4, 1930
and that death occurred, on the date stated above, at 1:25 a.m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Lab
(Signed) H Ray Hatch, M. D.
May 9, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mayville, Wisconsin
Date of Burial May 12 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71058

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. B
Primary Registration District No. 21 J-0
Local Registrar's No. 99
93
8870
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Charlesworth
(a) Residence. No. R.D. 7 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) March 21-1861
7. AGE: Years 69, Months 1, Days 18. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Oasis Utah
PARENTS
10. NAME OF FATHER: Tom Charlesworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England
14. Informant: Mrs Maude Shaw
(Address) Idaho Falls Ida. R.D. 7
15. Filed May 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 26, 1930 to May 8, 1930
that I last saw him alive on May 8, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. Sutton, M. D.
May 10, 1930 (Address) Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Richfield Utah
Date of Burial: 5/12 1930
20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71059

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 13
Primary Registration District No. 1 0 0
(No. I. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 94

24

2. FULL NAME Nile Humble
(a) Residence. No. ..... St. Victor, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 6

7. AGE Years 2 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Victor, Idaho

PARENTS
10. NAME OF FATHER J. Scott Humble
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jackson, Wyoming
12. MAIDEN NAME OF MOTHER Edith Pearsely
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Victor, Idaho

14. Informant J. Scott Humble
(Address) Victor, Idaho

15. Filed May 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 9, 1930
that I last saw him alive on May 9, 1930
and that death occurred, on the date stated above, at 11-30 P m.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro Spinal Meningitis
(duration) yrs. mos. 20 hrs
CONTRIBUTORY (Secondary) Myocarditis acute
(duration) yrs. mos. 6 hrs

18. Where was disease contracted if not at place of death? Victor
Did an operation precede death? no Date of ——
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture
(Signed) [signature], M. D.
5/10/30, 19.. (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Victor, Idaho — Date of Burial May 12 1930

20. Undertaker Jack A. Wood — Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71060

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2 / N-D
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9 V —

161a

2. FULL NAME Anglesey, Willma

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): newborn

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 9, 1930

7. AGE Years | Months | Days | If LESS than 1 day, 3 hrs. 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Anglesey, Walter J.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Labelle Idaho
12. MAIDEN NAME OF MOTHER Hall, Alice L.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho Falls, Idaho

14. Informant L. D. S. Hospital
(Address) Idaho Falls Idaho

15. Filed May 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to ....., 19..
that I last saw her alive on May 9, 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Prematura 7 months

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. West, M. D.
May 9, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker none | Address

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71062

PLACE OF DEATH
County of Jerome
City of Hagerman

Registration District No. 23
Primary Registration District No. 2017
(No. at Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

90

2. FULL NAME Alice Robins
(a) Residence. No. Hagerman RF D #1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of widowed

6. DATE OF BIRTH (month, day and year) Nov 6 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work nothing
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Ark

PARENTS

10. NAME OF FATHER William Langford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Mollie Fife
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. E. McKee
(Address) Jerome Ida

15. Filed July 1, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29, 1930, to June 4, 1930
that I last saw her alive on May 29, 1930
and that death occurred, on the date stated above, at 12 P m.
The CAUSE OF DEATH* was as follows:
Mitral stenosis and arteriosclerosis
(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Electrocardiograph blood pressure
(Signed) S Hopper, M. D.
6-5, 1930 (Address) Hagerman

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hagerman Ida	June 6 1930
20. Undertaker	Address
P J Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71063

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isadora Adeline Brown Beech

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 13 1842

7. AGE	Years	Months	Days	If LESS than 1 day,
	87	10	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Green Erie Co. Penn.

PARENTS

10. NAME OF FATHER Ezekiel Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Katherine Slawson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Hattie L. Thorne
(Address) 284 E. St. Salt Lake City

15. Filed 6/17, 1930 Chas F. Zellers Inc. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to June 17, 1930
that I last saw her alive on June 15, 1930
and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:
Cardiac Asthenia
with Pulmonary Oedema
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. B. Zeller M. D.
7/17, 1930 (Address) Jerome Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasant Grove Utah Co. Utah	19
20. Undertaker	Address

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71064

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME James M Miller

(a) Residence. No. St. 49 Price
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lettie Miller

6. DATE OF BIRTH (month, day and year) May 1 - 1858

7. AGE Years 71 Months 10 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Port. Barne Pa

PARENTS

10. NAME OF FATHER J. J. Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Elizabeth —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Lettie Miller
(Address) Jerome

15. Filed 4/28, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cancer
left submaxillary glands
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Sam F Price, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: Mar 29 1930

20. Undertaker: D A L Herisson
Address: Jerome Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71065

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Agnes Maria Anderson
(a) Residence. No. Jerome St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 21 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
(or) HUSBAND of / WIFE of Andrew Anderson

6. DATE OF BIRTH (month, day and year) Jan 9th 1867

7. AGE Years 63 Months 3 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Stockholm
(State or country) Sweden

PARENTS
10. NAME OF FATHER P. Palm
11. BIRTHPLACE OF FATHER (city or town) Sweden
(State or Country)
12. MAIDEN NAME OF MOTHER Herrmina Constantina Aberg
13. BIRTHPLACE OF MOTHER (city or town) Stockholm
(State or Country) Sweden

14. Informant Andrew Anderson
(Address) Jerome Idaho

15. Filed 4/20, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany, 1928, to Apl 20, 1930
that I last saw her alive on Apl 20, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Raynaud disease
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Consultation
(Signed) Thos F Schmerschall, M. D.
May 22, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: April 20 1930

20. Undertaker: D A L Harrison
Address: Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71067

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

122

2. FULL NAME Sallie White Walling
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If ~~married, widowed~~, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ ~~Noah Walling~~

6. DATE OF BIRTH (month, day and year) May 20 1861

7. AGE Years 68 Months 11 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) McMinnville Tenn

PARENTS
10. NAME OF FATHER Alex White
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Hellen Knight
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chalmers Tenn

14. Informant Alice Silvius
(Address) Jerome

15. Filed 5/1, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jun 14, 1930 to April 24, 1930
that I last saw her alive on April 24, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Tapping Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) Sam T Price M. D.
, 19 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome
Date of Burial 5-1 1930

20. Undertaker D R L Herisson
Address Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71068

PLACE OF DEATH

County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Samuel T Faddis

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Julia Faddis

6. DATE OF BIRTH (month, day and year): May 17 - 1885

7. AGE: Years 44, Months 10, Days 16. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Woods Cross Utah

PARENTS

10. NAME OF FATHER: Alexander M Faddis Jr
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Edenburgh Scotland
12. MAIDEN NAME OF MOTHER: Marry Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Edenburgh Scotland

14. Informant: Alexander M Faddis Jr
(Address): Salt Lake Utah

15. Filed 4/4, 1930. Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to Apl 3, 1930
that I last saw him alive on Apl 1, 1930
and that death occurred, on the date stated above, at 6p m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary): Myocarditis
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) John F Schmershall, M. D.
Apl 12, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: 4/6 1930

20. Undertaker: D. A. Harrison
Address: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71069

PLACE OF DEATH

County of Jerome
City of Jerome
Registration District No. 18
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME May A Garman 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 26 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Summerset Ohio
(State or country)

PARENTS

10. NAME OF FATHER Aaron P Ashbrook
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Margaretta Sims
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Jerry Garman
(Address) Jerome

15. Filed 5/19, 1930. Clara F Zeller Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1930, to May 18, 1930
that I last saw her alive on May 18 1930
and that death occurred, on the date stated above, at 1 13 P. m.

The CAUSE OF DEATH* was as follows:
Coronary Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. F. Zeller, M. D.
5/20, 1930. (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Cemetery	May 21 1930
20. Undertaker	Address
D. R. Harrison	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MAKE RECORD, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71070

PLACE OF DEATH

County of Jerome
City of Jerome
Registration District No. 18
Primary Registration District No.
(No.)
Local Registrar's No. 40

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl A Potter

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 14 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Stevenspoint
(State or country) Wis

PARENTS

10. NAME OF FATHER Jerome Potter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Anna Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant E.D. Potter
(Address)

15. Filed 4/30, 1930 Chas F Zeller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to April 29, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Emphysema Chronic
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. F. Zeller, M. D.
5/20, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome	May 3 1930
20. Undertaker	Address
D A Harriman	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

State Form No. 825—1921. Approved by Dept. of Efficiency.

RECEIVED JUL 9 1930

PLACE OF DEATH

~~Washington~~ Idaho State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 71071

Registered No.

County of ~~Spokane~~ Kootenai

City or Town of ~~Rockford~~ Worley

Registration Dist. No. 9 No. ,

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME L. E. Rue

90

(a) Residence No. St.;

(Usual place of abode)

(b) If non-resident, give city or town, and state Ida.

(c) How long in Registration Dist. yrs. mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars

3. Sex: male

4. Color or Race: Wht

5. Single, Married, Widowed or Divorced (Write the word): Married.

5. (a) If married, widowed or divorced:
Husband of Edna Rue
or
Wife of —

6. Date of birth: Oct (Month) 21 (Day) 1887 (Year)

7. Age 42 yrs. 8 mos. 4 ds. If less than one day hrs. or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. Birthplace (City or town)
(State or Country) Wash.

PARENTS

10. Name of Father J C Rue

11. Birthplace of Father (City or town) (State or Country) Wisc.

12. Maiden name of Mother Evelyn Selden

13. Birthplace of Mother (City or town) (State or Country) New York

14. Informant O A Rue
Address Edwald Wn

15. Filed June 27, 1930
Registrar.

Medical Certificate of Death

16. Date of Death June (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1927, to June 20, 1930 that I last saw him alive on June 20, 1930 and that death occurred on the date stated above at m. (State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.)

The CAUSE OF DEATH was as follows:

(Primary) Organic Heart Lesion.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18. Where was disease contracted if not at the place of death?

(a) Did an operation precede death? Date of

(b) Was there an autopsy?

(c) What test confirmed diagnosis?

(Signed) L Clinton M. D.

, 192 Address

19. Place of Burial, Cremation or Removal [illegible] | Date of Burial , 192

20. Undertaker Smith & Co | Address

I HEREBY CERTIFY, upon honor, That I have made the effort but was unable to secure answers to questions
(Insert numbers of unanswered questions)

(Signature of Undertaker)

V. S. No. 1—20M—11-16-22

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Died at Worley. Removed to Rockford Wash.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71072

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 74
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

9.

2. FULL NAME Beaula May Alley

(a) Residence. No. Near Post Falls, St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	6	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kellogg
(State or country) Ida.

PARENTS

10. NAME OF FATHER Waldo Alley
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Washington
12. MAIDEN NAME OF MOTHER Cecil Vanover
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ill.

14. Informant Waldo Alley
(Address) Post Falls, Ida. R.F. D.

15. Filed 6/16, 1930 A.J. Sturges M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 9th, 1930
that I last saw her alive on June 9th, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Whooping Cough
Pneumonia
(duration) yrs. mos. 7 ds.
Colitis
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) F.L. McCauley M. D.
June 12, 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Foret Cemetery	6-12-30 19
20. Undertaker	Address
Mooney Mortuary	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Dwyer

PLACE OF DEATH

County of Kootenai

City of ~~Kootenai~~ Coeur d'Alene.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71074

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 76

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Christian A Pederson

(a) Residence. No. 518 West Summit St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Pederson

6. DATE OF BIRTH (month, day and year): Nov 11, 1869

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	7	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): Coeur d Alene Homes

(c) Name of employer: Old Peoples Home

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Peter Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Annie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mrs Bertha Pederson

(Address) Coeur d Alene, Ida.

15. Filed 6/16, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to ....., 19..

that I last saw him alive on June 12, 1930

and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis (Probable)

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Arterio sclerosis. Hypertension

Not known (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J C Dwyer, M.D.

June 14, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: June 16 1930

20. Undertaker: R B Mooney

Address: Cd'A Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Anderson

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71075

PLACE OF DEATH

County of Kootenai

City of ~~Kootenai~~ Coeur d'Alene

Registration District No. 20

Primary Registration District No. 1050

Local Registrar's No. 77

(No. PDA Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Larson

41

(a) Residence. No. ..... St. Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. — yrs. — mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Single

5. Single, Married, Widowed, or Divorced (write the word): White

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 1890

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	—	—	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Timber Woker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Winton Lumber Co

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Winton Lumber Co Office

(Address) Coeur d'Alene Ida

15. Filed 6/16/, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 11, 1930

that I last saw him alive on June 11, 1930

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

Pyemia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Fractured pelvis

..... (duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.

June 14, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: June 14 1930

20. Undertaker: R B Mooney

Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71076

Local Registrar's No. 78

107

2. FULL NAME Ruth C. Hammond

(a) Residence. No. 504 So 11th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 22 1902

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	6	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Teacher Grade

(b) General nature of industry, business, or establishment in which employed (or employer) Schools

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS

10. NAME OF FATHER Truman Hammond

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc

12. MAIDEN NAME OF MOTHER Ida Girerd

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant T. C. Hammond
(Address) Coeur d'Alene Ida

15. Filed 6/16/, 1930 H. J. Sturges. Registrar M.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to June 14, 1930

that I last saw her alive on June 14, 1930

and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Respiratory paralysis (Cause unknown) Five physicians in Consultation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hysteria (Dr Semple) Spokane, Wash

..... (duration) ..... yrs. 5 mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) E L Spohn, M. D.

6-14-, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery

Date of Burial June 17 1930

20. Undertaker R. B. Mooney

Address

RECEIVED JUL 5 1930
RECEIVED NOV 10 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71077

Local Registrar's No. 79

2. FULL NAME John A Davis

(a) Residence. No. 614 North 16th St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah ann Davis

6. DATE OF BIRTH (month, day and year) April 20, 1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	1	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Richard Thorpe

(Address) Coeur d'Alene Ida

15. Filed 6/17, 1930 W. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 15, 1930

that I last saw him alive on June 9, 1930

and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E H Teed, M. D.

10-31, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	6/18 1930
20. Undertaker	Address
P B Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71078

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 80

1869

2. FULL NAME James Hause

(a) Residence. No. Hayden Lake Rd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	63	-	-	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brush Burner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Forestry Service

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mark Hause
(Address) Hayden Lake, Ida.

15. Filed JUNE 19-, 1930. N. J. Sturges M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
(Head crushed) By falling tree (camp 17) Hinton Lumber Co

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P B Mooney M. D.
June 19, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	June 21 19

20. Undertaker P B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
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RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71079

PLACE OF DEATH
County of Kootenai
City of Coeur d Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 81

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Mc Intyre

(a) Residence. No. 1024 N 7th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Mc Intyre

6. DATE OF BIRTH (month, day and year) 1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Mary Mc Intyre
(Address) Coeur d Alene Idaho

15. Filed JUNE 19, 1930 H. J. Sturges. M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1930, to June 16 1930, that I last saw him alive on June 15 1930, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Not known yrs. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J. C. Wynn, M. D.
June 19, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	June 19 30
20. Undertaker	Address
W. D. Mooney	Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

• WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71080

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 82

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Bertha Ethel Easley

(a) Residence. No. Fruitland Addition Coeur d'Alene St.
(Usual place of abode)
Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 6 1887

7. AGE	Years	Months	Days	If LESS than 1 day,
	43	8	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Bentonville
(State or country) Arkansas

PARENTS

10. NAME OF FATHER Manson Easley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Annie Stiles
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. N. Easley
(Address) Coeur d'Alene Idaho

15. Filed 6/23, 1930 W. J. Sturgeo
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 12, 1930
that I last saw her alive on June 12, 1930
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. one ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinalysis
(Signed) Howard T. Anderson M. D.
June 14, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery Coeur d'Alene	6/15 1930
20. Undertaker	Address
Cassidy Funeral Home	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

PLACE OF DEATH

County of Kootenai

City of Chilco

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71081

Local Registrar's No. 83

127

2. FULL NAME Wm Edward ~~Sisco~~ Cisco

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1857 - N - Dont Know

7. AGE Years 72 Months 7 Days Dont Know If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ore.

PARENTS

10. NAME OF FATHER Wm Wesley Cisco

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Nancy Stevens

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant .....
(Address) C D Cisco

15. Filed 6/23, 1930 H. J. Sturges MD. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to ....., 19....

that I last saw him alive on June 1, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

June 4, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rimrock Cemetery — Date of Burial 6-4 1930

20. Undertaker Cassedy Funeral Home — Address Wallace

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21089

PLACE OF DEATH
County of Kootenai
City of Coeur d' Alene

Registration District No.
Primary Registration District No.
Local Registrar's No. 84
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David E. Hagadone

(a) Residence. No. 623 - Sherman St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Ada E. Hagadone

6. DATE OF BIRTH (month, day and year) 1851 - 3 - 5

7. AGE	Years	Months	Days	If LESS than 1 day,
	79			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Filer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Dan-Know Hagadone
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ada E. Hagadone
(Address)

15. Filed 6/3, 1930 H. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to , 19
that I last saw him alive on June 3, 1930
and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Glomerulo-nephritis } 2 years
Myocardial Degeneration }
Myocardial Failure 2 weeks
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Harold T. Anderson M. D.
June 4, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C D Alene	6-5 1930
20. Undertaker	Address
Cassedy Funeral Home Coeur d'Alene Ida	C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
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RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71083

PLACE OF DEATH

County of Kootenai

City of Coeur D Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 85

(No.) 740

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Miller

(a) Residence. No. 1701 Coeur D' Alene Ave. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23, 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER John Good

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Dorety

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Mrs. R. Downing,

(Address) Coeur D' Alene, Idaho

15. Filed 6/30, 1930 W. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1930, to June, 1930, that I last saw h~~e~~r alive on June 27, 1930 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Harold J. Sturges, M. D.

6-30, 1930 (Address) Old Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	June 30 1930
20. Undertaker R. B. Mooney	Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71084

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 86

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Alvina Neils

(a) Residence. No. 902 - Young St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of August Neils

6. DATE OF BIRTH (month, day and year) 1892-4-25

7. AGE: Years 38 | Months 2 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10. NAME OF FATHER: Frederic Marks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Willemana Hochtritt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: August Neils
(Address)

15. Filed 6/30, 1930 Harold J. Sturgea, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 18, 1930

that I last saw her alive on June 18, 1930

and that death occurred, on the date stated above, at 4:00 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma - in left iliac fossa, no operation or autopsy, therefore exact location cannot be determined

..... (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harold T. Anderson, M. D.

June 25, 1930 (Address) C Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cem. CD Alene | Date of Burial: 6-26 1930

20. Undertaker: Cassedy Funeral Home | Address: CD Alene

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71085

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

48B

2. FULL NAME Martha Jane Cady

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 22 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of E W Cady

6. DATE OF BIRTH (month, day and year) July 3. 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	56	9	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin Pierce County

PARENTS

10. NAME OF FATHER Richard Sheldista

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Emma Arton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant E W Cady
(Address) Rathdrum Idaho

15. Filed 6/30, 1930 Harold J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20. 1930, to May 2. 1930
that I last saw her alive on May 1st 1930
and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis.
(duration) 2 or 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) about 1 yr. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Frank Heyn, M. D.
6/3. 1930. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery Coeur d'Alene	6/4 1930
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 62

DO NOT WRITE IN THIS SPACE
State File No. 71087

PLACE OF DEATH
County of Latah
City of Near Genesee

Registration District No.
Primary Registration District No. 2142
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

129

2. FULL NAME John Johann

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6. DATE OF BIRTH (month, day and year) Feb 15-1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	4	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER John Johann
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Anna Schumacher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Catherine Johann
(Address) Genesee Idaho

15. Filed 6-24, 1930 W. H. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to Apr 27, 1930
that I last saw h[illegible] alive on Apr 27, 1930
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Usual Symptoms
(Signed) W. H. Shaw, M. D.
6-24, 1930 (Address) Genesee

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Genesee	6/26 1930
20. Undertaker F. R. Short	Address Moscow

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71088

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2165

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

4-30

2. FULL NAME Forest J. Vowell.

(a) Residence. No. Farm St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 6 1870

7. AGE: Years 60 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: L. W. Vowell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Margret Sargent.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs Forest J. Vowell
(Address): Palouse Wash.

15. Filed June 10th, 1930 J. Jr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from a
June 1st, 1930, to June 5th, 1930
that I last saw him alive on June 5th, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Cancer of face.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. Jr. Thompson M. D.
June 10th, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cem — Date of Burial: June 10 1930

20. Undertaker: C. H. Grim — Address: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71089

PLACE OF DEATH
County of Latah
City of Pattatch

Registration District No. 65
Primary Registration District No. 2145
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

45

2. FULL NAME James Grant

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 5 - 1845

7. AGE: Years 85 | Months 1 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): " "
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Rhoda Grant
(Address) Palouse Wash

15. Filed June 3rd, 1930 Dr Geo. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15th, 1930, to May 30th, 1930
that I last saw him alive on May 30th, 19
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of May 16th
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) F. C. Gibson, M. D.
June 3rd, 1930 (Address) Pattatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Freeze Cemetery | Date of Burial: June 3 1930

20. Undertaker: J M Irwin | Address: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71090

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 214
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

92

2. FULL NAME Lela May McGahan.

(a) Residence. No. X St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30/1875

7. AGE Years 57 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS
10. NAME OF FATHER J Lawson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs Elmer Sanders.
(Address) Palouse Wash.

15. Filed July 26th, 1930 Dr Jas. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9th, 1930, to July 25th, 19
that I last saw her alive on July 25th 19
and that death occurred, on the date stated above, at 7 20 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary Thrombosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) - Gangrene of gall bladder
(duration) yrs. mos. 16 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 11th
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. C. Gibson, M. D.
July 26th, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: E H Irwin
Date of Burial: June 30 1930
20. Undertaker
Address: Palouse Wash.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71091

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. .....)
Local Registrar's No. .....
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

44 B

2. **FULL NAME** Karolina Charoletta Westberg

(a) **Residence.** No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 25-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10 NAME OF FATHER: Olavos. Olson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Chas Borden
(Address): Troy Idaho.

15 Filed June 30, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 1 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 18 1930 to June 1st 1930
that I last saw her alive on June 1st 1930
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH*, was as follows:
Chronic Myocarditis
(duration) 12 yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Senility
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Chas. A. Bayer M. D.
June 2, 1930. (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Westdala cem	June 4 1930
20. Undertaker: John J Pickerd	Address: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71092

PLACE OF DEATH
County of Latah
City of Kendrick

Registration District No. 63
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME May Matilda Barber

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 16 - 1854

7. AGE: 75 Years | Months: 5 | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ottawa Canada

PARENTS

10. NAME OF FATHER: Simon Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Agnes Langfellow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: L J Herres
(Address): Kendrick

15. Filed June 16, 1930 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8:40 p m.
The CAUSE OF DEATH* was as follows:
Sarcoma of hip
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E H Field, M. D.
June 13, 1930 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kendrick | Date of Burial: June 16 1930

20. Undertaker: Brower & Warner | Address: Lewiston

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71093

PLACE OF DEATH

County of Latah
City of Kendrick
Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Fred Johns

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 25 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	3	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER William Johns
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs Tom McDowell
(Address) Kendrick, Idaho

15. Filed June 16, 1930 B. F. Nesbit
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to June 15, 1930
that I last saw him alive on June 15, 1930
and that death occurred, on the date stated above, at 4 p. m.
The CAUSE OF DEATH* was as follows:
Carcinoma stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. A. Meyer M. D.
June 16, 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kendrick, Idaho.	6/17 1930
20. Undertaker	Address
John J. Pickerd	Troy, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71096

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Ole Iverson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Olive Iverson

6. DATE OF BIRTH (month, day and year): June 1, 1861

7. AGE: Years 68, Months 11, Days 30. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Iver Amundfos
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Ragnel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Hans Iverson
(Address): Moscow, Ida.

15. Filed 6/19, 1930. Harry E. Lowe, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 31, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1928, to Sat. 5/31, 1930
that I last saw him alive on May 31, 1930
and that death occurred, on the date stated above, at 5:00 p. m.
The CAUSE OF DEATH* was as follows: Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma — of bile ducts —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Chas. L. Gorbeau, M. D.
June 2, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Genesee Valley Cemetery
Date of Burial: 6/3 1930

20. Undertaker: H. R. Short
Address: Moscow

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71097

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

90

2. FULL NAME Flora Elizabeth McCauley

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. E. McCauley

6. DATE OF BIRTH (month, day and year) March 30, 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lexington
(State or country) Mo.

PARENTS

10. NAME OF FATHER C.W. Sanders

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Kansas

12. MAIDEN NAME OF MOTHER Mary E. Harrow

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Mo.

14. Informant W.E. McCauley
(Address) Moscow, Idaho

15. Filed 6/19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 28, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1928, 19..., to May 27, 1930, 19...
that I last saw her alive on April 22, 1930, 19...
and that death occurred, on the date stated above, at 10:30 P m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Inflamatory rheumatism

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. L. Gritman, M. D.
5/28/30, 19... (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dayton, Wash.	5/30/30 19

20. Undertaker	Address
H. C. Frost	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71098

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 20
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Loyd Peter Terteling

(a) Residence. No. ..... St. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 14, 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Grading
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS

10. NAME OF FATHER Joe A. Terteling
11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Vady NIXON
13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Mo.

14. Informant J.A. Terteling
(Address) Moscow, Ida.

15. Filed 6/19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24, 1930 to May 21, 1930
that I last saw him alive on May 20. 1930
and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:
Acute aortic insufficiency.
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute influenza.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not known.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only
(Signed) O Armstrong, M. D.
May 22, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	5/22/30 19
20. Undertaker	Address
H. R. Short	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71099

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.)
Local Registrar's No. 19

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Nirem M. Hawley

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5C yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male ~~Male~~	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha F. Hawley

6. DATE OF BIRTH (month, day and year) Jan. 9, 1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	4	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer (20 yrs.)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Knox county
(State or country) Ill.

PARENTS

10. NAME OF FATHER Ira Hawley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Elvira Rilley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant Martha F. Hawley
(Address) Moscow, Idaho

15. Filed 6/19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18/ 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to May 17, 1930
that I last saw h im alive on May 17, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of ear.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. V. Fortune, M. D.
5/20, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	5/20/30 19

20. Undertaker W. R. Short — Address Moscow

RECEIVED JUN 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71100

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

49

2. FULL NAME Susan Caroline Maclennan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W.B. Maclennan

6. DATE OF BIRTH (month, day and year) Sept. 21, 1881

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Audabon
(State or country) Iowa

PARENTS

10. NAME OF FATHER Frank Comstock
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Iowa
12. MAIDEN NAME OF MOTHER Katherine Paulus
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Ohio

14. Informant Frank Comstock
(Address) Moscow, Idaho

15. Filed 6/19, 1930 J. Harry Einhorn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 3, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to May, 1930
that I last saw her alive on May 2nd 1930
and that death occurred, on the date stated above, at 2:20 P.m.
The CAUSE OF DEATH* was as follows:
Uterine Carcinoma c̄ Metastases
..... (duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Secondary Anaemia - Cerebral edema ..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Aug 1926
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] Magee, M. D.
5/31, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 5/5 1930

20. Undertaker: H. R. Short
Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 511-45M 1-30

RECEIVED JUL 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Deary

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66

Primary Registration District No. 2145

(No. ....., ... St.)

File No. 7101

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dale Earal Warner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 11 (Day) 1930 (Year)

7. AGE: 0 Yrs. 0 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: enfant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Deary, Idaho

10. NAME OF FATHER: John Fredrick Warner

11. BIRTHPLACE OF FATHER (State or Country): Spaulding Nebr.

12. MAIDEN NAME OF MOTHER: Chloie May Whybark

13. BIRTHPLACE OF MOTHER (State or Country): Deary Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter K. Werelius
(Address) Bovill, Idaho

15. Filed Apl. 15 1930 E. B. Flasher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1930 (Year) 16A

17. I HEREBY CERTIFY, That I attended deceased from April 8 1930, to April 10 1930, that I last saw h-im alive on April 10 1930 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Asphyxia Due to mucous in throat

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Walter K. Werelius M. D.

..... 19..... (Address) Bovill, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Deary, Ida. DATE OF BURIAL: Apl. 11 1930

20. UNDERTAKER: H. R. Short ADDRESS: Moscow, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71102

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 27

(No.) 75
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frances Randall

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jessie Randall

6. DATE OF BIRTH (month, day and year) Sept 8, 1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Oakland
(State or country) Oregon

PARENTS

10. NAME OF FATHER Fendel Southerlin
11. BIRTHPLACE OF FATHER (city or town) Ind.
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant John Randall
(Address) Moscow, Ida.

15. Filed July 9, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1928 to June 22, 1930
that I last saw her alive on June 20, 1930
and that death occurred, on the date stated above, at 3:30 P m.
The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
June 23, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	6/24/30

20. Undertaker W. R. Short — Address Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71103

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 23

(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore Roosefelt Milsap

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 28, 1904

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
25	7	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Truck driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Moscow Idaho

PARENTS

10. NAME OF FATHER: Joseph L. Milsap

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ten.

12. MAIDEN NAME OF MOTHER: Della M. Cary

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: J.L. Milsap
(Address) Moscow, Idaho

15. Filed July 9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 6, 1930 that I last saw him alive on June 6, 1930 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows: Acute toxemia of streptococcus origin

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Laceration left knee.

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes. Date of June 6 1930 Drainage of left thigh

Was there an autopsy? No

What test confirmed diagnosis? Mucronopeal and cultural

(Signed) [signature], M. D.

6/9, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 6/9/30 19

20. Undertaker: H. R. Short

Address: Moscow

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71104

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 24

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

105

2. FULL NAME Thomas Tucker Suddreth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Suddreth

6. DATE OF BIRTH (month, day and year): Mar. 5, 1848

7. AGE: Years 82, Months 4, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Millageville Georgia

PARENTS

10. NAME OF FATHER: Allen R. Suddreth

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Car.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known

14. Informant: J.A. Suddreth
(Address): Moscow, Ida.

15. Filed July 9, 1930. J. Lam Einhouse, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 16, 1930
(Month) June 7 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 16, 1930
that I last saw him alive on June 16, 1930
and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma when first seen, June 15 begun as attack of Senile Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) F. M. Leitch, M. D.

6/17, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 6/18/30 19

20. Undertaker: H. R. Short
Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71105

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 25
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Emma Edmundson Urquhart

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Urquhart

6. DATE OF BIRTH (month, day and year) Dec. 10, 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	6	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Fabius
(State or country) N.Y.

PARENTS

10. NAME OF FATHER Rowley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Rachel Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant C.S. Edmundson
(Address) Seattle, Wash.

15. Filed July 9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to June 20, 1930
that I last saw her alive on June 15, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of liver
Don't Know, Secondary
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) F. W. Leitch, M. D.
6/21, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	6/22/30 19

20. Undertaker H.R. Stout
Address Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71107

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 66
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

49

2. FULL NAME Annie E Nicholson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Parker C Nicholson

6. DATE OF BIRTH (month, day and year) May 14 1875

7. AGE Years 66 Months 0 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Eric Erickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant P. C. Nicholson
(Address) Winchester

15. Filed 6/21, 1930 P C Dewey
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1930 to June 9, 1930
that I last saw her alive on June 9, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Adeno-Carcinoma
Benign? for
(duration) 25 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Recurrence Malignant
(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes No Date of Apr 21-1930
Was there an autopsy? .....
What test confirmed diagnosis? Microscopic
(Signed) J. E. McLaughlin M. D.
June 9 1930 (Address) Winchester Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal I.O.O.F. Cem. Craigmont Ida Date of Burial June 11 1930

20. Undertaker Craigmont Lewis Co. Address Craigmont Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71108

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2129
Local Registrar's No. 10
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Fox
(a) Residence. No. ..... St. Sheridan, Wyo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 26-1851

7. AGE: 78 Years, Months: 11, Days: 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: John Fox
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Jerusha Colson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: F. M. Fox
(Address) Winchester Idaho

15. Filed 6/7, 1930. R. E. Duffy, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 4, 1930
that I last saw him alive on June 1, 1930
and that death occurred, on the date stated above, at 6:30 a m.
The CAUSE OF DEATH* was as follows:
Chr. myocarditis
Auricular Fibrillation
(duration) ? yrs. ? mos. ds.
CONTRIBUTORY (Secondary) Chronic nephritis Arterio-Sclerosis
(duration) ? yrs. ? mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Diag & Lab.
(Signed) Ralph M. Alley, M. D.
6/6, 1930 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Craigmont Idaho — Date of Burial: 6/7 1930

20. Undertaker: Brower-Dunn Co. — Address: Lewiston Idaho

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71109

PLACE OF DEATH
County of Lewis
City of Winchester
Registration District No. 6
Primary Registration District No. 217
Local Registrar's No. 9
(No.) Winchester Hospital, Winchester, Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. FULL NAME Baby Hill

(a) Residence. No. Craigmont, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 9 hrs How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day,	hrs. or min.
				9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester Idaho.

PARENTS

10. NAME OF FATHER F. W. Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Nez~~ Reubens Idaho.
12. MAIDEN NAME OF MOTHER Mayzie Pettigrew
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clarkston Wash.

14. Informant F. W. Hill
(Address) Craigmont, Idaho.

15. Filed 6/6, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4 am June 4, 1930; to 1 PM June 4, 1930
that I last saw ~~him~~ alive on June 4, 1930
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Premature birth. 6 mo gestation.

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Ralph M. Alley, M. D.
June 4, 1930 (Address) Winchester, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gilletes cemetery	6/5 1930
20. Undertaker F W Hill	Address Craigmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

JUL 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71112

Registration District No. ____
Primary Registration District No. ____
Local Registrar's No. 12

PLACE OF DEATH

County of Lincoln
City of Dietrich

(No. Ranch 4 Miles S E Dietrich
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME M K, Savage - (Marion K Savage) 69

(a) Residence. No. ____ St. ____
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 2 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	7	26	____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9. BIRTHPLACE (city or town) Brigham
(State or country) Utah

PARENTS

10. NAME OF FATHER Mathew Savage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant M C Savage
(Address)

15. Filed Jun 30, 1930 J E Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to June 28, 1930
that I last saw h~~er~~, alive on June 10 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Acute Nephritis,
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) Not known,
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of ____
Was there an autopsy? No
What test confirmed diagnosis? ____
(Signed) ____ M. D.
____, 19____ (Address) Lostine Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Idaho	June 30 1930

20. Undertaker C E Hickok Address Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

File No. 7113

Registered No. 30

County of Madison

City of Rexburg

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Schwendiman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb 12th 1885 (Month) (Day) (Year)

7. AGE: 45 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Swicherland

10. NAME OF FATHER: John Lanz

11. BIRTHPLACE OF FATHER (State or Country): Swicherland

12. MAIDEN NAME OF MOTHER: Elizebeth Tanner

13. BIRTHPLACE OF MOTHER (State or Country): Swicherland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Schwendiman

(Address) Newdale Idaho

15. Filed 7/5 1930

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 5 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1930 to July 4 1930 that I last saw her alive on July 4 1930 and that death occurred on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Hepatitis

Acute Pancreatitis

Gall stones

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. B. Rigby M. D.

7/5 1930 (Address) Rexburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newdale Idaho — DATE OF BURIAL: July 7 1930

20. UNDERTAKER: Wm. D. Keller — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7114

Registered No. 30

1. PLACE OF DEATH

County of Madison

City of Burton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 5178

(No. ..... St.)

2. FULL NAME Phyllis Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	

6. DATE OF BIRTH: May (Month) 18th (Day) 1927 (Year)

7. AGE: 3 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burton Ida.

10. NAME OF FATHER: Carl Jensen

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Elizabeth Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Burton Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) My Carl Jensen

(Address) Rexburg R.F.D. #1

15. Filed 6/11 1930

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1930 to June 9 1930

that I last saw her ~~alive on~~ June 9 1930

and that death occurred on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:

Drowning
accidental

Post Mortem Call -

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin F. Rich M. D.

6/11 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton Idaho. DATE OF BURIAL: June 13 1930

20. UNDERTAKER: Wm J. Keller ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7115

PLACE OF DEATH

County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2915
(No.)
Local Registrar's No. 38

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Henry L. Johnson

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Johnson

6 DATE OF BIRTH (month, day and year) Dec 22 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10 NAME OF FATHER Orphus H. Johnson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Wisconsin
12 MAIDEN NAME OF MOTHER Mary Oliver
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wisconsin

14 Informant Mary Johnson
(Address) Rupert Idaho

15 Filed 6-27, 1930 E. E. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 23, 1930,
that I last saw him alive on June 23, 1930,
and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:
Septicemia, originating in cut near left thumb
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Exposure in cold water
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Opening & drainage of Date of lg.
Was there an autopsy? no
What test confirmed diagnosis? Symptoms & Lesions
(Signed) E. E. Elmore, M. D.
6-27, 1930 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
DeSota Wisconsin	June 30 1930
20. Undertaker W. C. Goodman	Address Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71125

PLACE OF DEATH
County of Nez Perce
City of Leland

Registration District No.
Primary Registration District No. 63
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas A. Dougherty 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Dougherty

6. DATE OF BIRTH (month, day and year) July 19 - 1870

7. AGE: Years 59 | Months 0 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10. NAME OF FATHER Harrison Dougherty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va
12. MAIDEN NAME OF MOTHER Anna Poore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Mrs. Anna Dougherty
(Address) Leland Ida.

15. Filed June 13, 1930 B. F. Nesbit
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not at all 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:
Influenza but apparently acute pneumonia of heart.
(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? sudden death - small foamy hemorrhage from lungs

(Signed) E H Fell, M. D.
June 12, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Leland Ida. — Date of Burial: June 15 1930
20. Undertaker: J. J. Pickerd — Address: Troy, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71126

Local Registrar's No.

1. PLACE OF DEATH
County of Nez Perce
City of Webb Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Black Eagle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian 4/4
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: (Month) (Day) 1 (Year)

7. AGE: 1 Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: James Black Eagle

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Annie Miller

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Black Eagle
(Address) Juneltwater Idaho

15. Filed 6-5-30 19 George Gaumnitz M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-31-30 19, to 6-5-30 19, that I last saw h[illegible] alive on 6-4-30 19, and that death occurred on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:
Pertussis
(Duration) yrs. mos. 6 ds.
Contributory (Secondary) Bronchio-Pneumonia
(Duration) yrs. mos. 4 ds.

(Signed) George Gaumnitz M. D.
6/5/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER: Family | ADDRESS: Juneltwater Idaho

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71126

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Sweetwater Vicinity or
City No. , St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Helen Jane Blackeagle
(a) Residence. No. Sweetwater St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23, 1929

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
1	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sweetwater
(State or country) Idaho

PARENTS
10 NAME OF FATHER James Blackeagle
11 BIRTHPLACE OF FATHER (city or town) Spalding
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Annie Miller
13 BIRTHPLACE OF MOTHER (city or town) Webb
(State or country) Idaho

14 Informant Corbett B. Lawyer
(Address) Lapwai, Ida

15 Filed 6/6/, 1930 L. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Whooping Cough
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Broncho-pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
6/5, 1930 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Sweetwater Cemetery
DATE OF BURIAL: June 7 1930
20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71127

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Cordelia Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	Indian 3/4	Single

6. DATE OF BIRTH: March (Month) 21 (Day) 1930 (Year)

7. AGE: Yrs. 2 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Caleb Carter

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Amera

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Amera
(Address) Lapwai Idaho

15. Filed 6/13/30 19 George Gaigmard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 9

16. DATE OF DEATH: 6 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-5-30 19..., to 6-13-30 19..., that I last saw her alive on 6-13-30 19..., and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ... yrs. ... mos. 7 ds.

Contributory (Secondary) Bronchio-Pneumonia

(Duration) ... yrs. ... mos. 1 ds.

(Signed) George Gaigmard M. D.

6/13/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Idaho — DATE OF BURIAL ... 19...

20. UNDERTAKER: family — ADDRESS: Lapwai Ida.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71127

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Cordelia Carter

(a) Residence. No. Lapwai, Idaho St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE 4/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 21, 1930

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS

10 NAME OF FATHER Caleb Carter

11 BIRTHPLACE OF FATHER (city or town) Lapwai
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Mary Amera

13 BIRTHPLACE OF MOTHER (city or town) Lapwai
(State or country) Idaho

14 Informant Corbett B. Lawyer Clerk
(Address) Lapwai Idaho

15 Filed 6/14/, 1930 M Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1930

17 I HEREBY CERTIFY, that I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Whooping cough
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Broncho-pneumonia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Lapwai Cemetery
DATE OF BURIAL June 14 1930

20 UNDERTAKER Brower-Wann Co
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1—200 d
V. S. No. 96

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71128

PLACE OF DEATH
County of Nezperce
City of Culdesac
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Sanford Lewis Wilson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 19 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) Pleasantville
(State or country) Missouri

PARENTS

10. NAME OF FATHER L. F. Wilson
11. BIRTHPLACE OF FATHER (city or town) Barbon Co.
(State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary L. Burnam.
13. BIRTHPLACE OF MOTHER (city or town) Cass County.
(State or Country) Missouri

14. Informant James Crowe.
(Address) Culdesac. Ida.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to March 4, 1930
that I last saw him alive on March 3, 1930
and that death occurred, on the date stated above, at 5:00 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 18 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) George Gaspard M. D.
3/4/30 19 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Culdesac Ida.	3-4- 1930
20. Undertaker	Address
H. R. Merchant	Clarkston Wash

FORM V. RECE 5-25 M. D. 19 JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State File No. 71129

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. Culdesac Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Mond Mapes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: April (Month) 1 (Day) 1888 (Year)

7. AGE: 42 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Anna Allison

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mapes, Husband
(Address) Culdesac Idaho.

15. Filed May 1930 George Gaugnard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: May (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 20 - 1929, to May 29 - 1930, that I last saw her alive on May 29 - 1930, and that death occurred on the date stated above, at 11.40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Number of years yrs. mos. ds.

Contributory (Secondary) Pulmonary Hemorrhage

(Duration) yrs. mos. 12 hours ds.

(Signed) George Gaugnard M. D.

5/29/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER: H. R. Merchant | ADDRESS: Clarkston, Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71130

Local Registrar's No.

Registration District No. 128

Primary Registration District No.

1. PLACE OF DEATH

County of Nez Perce

City of Sweetwater Idaho (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Austin Dwight Polley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. N

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH June (Month) 3 (Day) 1850 (Year)

7. AGE 80 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF Father Austin Polley

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Austin D. Polley

(Address) Sweetwater Idaho.

15. Filed 4-28-1930 George Gaignard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,

that I last saw h..... alive on ....., 19...,

and that death occurred on the date stated above, at 4:40 A.M.

The CAUSE OF DEATH* was as follows:

Died Suddenly

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) George Gaignard M. D.

4/28/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** 19...

20. UNDERTAKER Brewer-Wasson | **ADDRESS** Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71131

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce

City of Lapwai Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

2. FULL NAME John Wolf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Indian 4/4	Widowed

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

80 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Washington

10. NAME OF Father Not known

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed 4-15-30 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-6-30 19..., to 4-15-30 19...,

that I last saw him alive on 4-14-30 19...,

and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaspard M. D.

4/15/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lapwai Idaho — **DATE OF BURIAL** 4/16/30

20. UNDERTAKER Fanning — **ADDRESS** Lapwai Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71132

PLACE OF DEATH
County of Key Perell
City of Cuddesac

Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Mrs Rachel Ann Anderson

(a) Residence. No. Crowmont Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ John F. Anderson

6. DATE OF BIRTH (month, day and year) Sept. 22 - 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	~~Sept~~ 6	22 14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ht Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Robertson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Catherine Lingel
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Mrs Joseph Shinn
(Address) Cuddesac Idaho.

15. Filed April, 1930 Geo. Gaigmed M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-8-, 1930, to 4-8-, 1930
that I last saw her alive on 4-8-, 1930
and that death occurred, on the date stated above, at 11:00 P m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo. Gaigmed, M. D.
4/8/30, 19 (Address) Cuddesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fletcher Idaho	4/11/30 19
20. Undertaker	Address
N. R. Merchant	Clarkston Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71133

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce

City of near Lapwai Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Pawakee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Washington

10. NAME OF Father: Redwolf

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip Williams
(Address) Lapwai Idaho.

15. Filed April 1930 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

11B

16. DATE OF DEATH: April (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-9-30 19..., to 4-3- 1930, that I last saw him alive on 4-3- 1930, and that death occurred on the date stated above, at 5:09 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 21 ds.

Contributory (Secondary) Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) George Gaignard M. D.

4/3/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Idaho.

DATE OF BURIAL: 4/7/30 19

20. UNDERTAKER: Brawer-Wann

ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 9 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71134

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

1. PLACE OF DEATH

County of Blaine

City of Sweetwater, Idaho

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amelia Henry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 3/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: May (Month) 11 (Day) 1929 (Year)

7. AGE: Yrs. 10 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Joe Henry

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sophia Bronkhead

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Henry
(Address) Sweetwater Idaho

15. Filed March 1930 George Gaigmard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-3-30 19..., to 3-13- 1930, that I last saw h.. alive on 3-12- 1930, and that death occurred on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ... yrs. ... mos. 7 ds.

Contributory (Secondary) Broncho-Pneumonia

(Duration) ... yrs. ... mos. 3 ds.

(Signed) George Gaigmard M. D.

3/3/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sweetwater Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Family — ADDRESS Sweetwater Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71135

Registration District No. 728
Primary Registration District No.
Local Registrar's No.

1. PLACE OF DEATH
County of Nez Perce
City of Culdesac
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

304

2. FULL NAME John Lynn Green
(a) Residence. No. Culdesac St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Abby Alice Russell Green

6. DATE OF BIRTH (month, day and year) Sept 30th 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	5	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Attorney
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hillsville - Va.

PARENTS

10. NAME OF FATHER John W. Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Elizabeth Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant
(Address) Mrs John Lynn Green

15. Filed March, 1930 George Gaigmard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-17-, 1929, to , 19
that I last saw him alive on 3-26-, 1930
and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
Died Suddenly
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) George Gaigmard M. D.
3/3/30 19 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida.	3/5/30 19

20. Undertaker	Address
L. R. Merchant	Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71136

PLACE OF DEATH
County of Nez Perce
City of Lapwai

Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert McKee

90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 8/31/1864.

7. AGE 65 Years Months 6 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer and
(b) General nature of industry, business, or establishment in which employed (or employer) Capitalist
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cincinnati Ohio.

PARENTS

10. NAME OF FATHER Alexander McKee.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pine Creek Ohio
12. MAIDEN NAME OF MOTHER — Sievers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant E J McKee
(Address) Sandpoint, Idaho

15. Filed March, 1930. George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to March 3, 1930
that I last saw him alive on March 2, 1930
and that death occurred, on the date stated above, at 10 30 A m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E G Bracecock M. D.
3/4, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston, Idaho. Date of Burial 3/6 1930

20. Undertaker Brower-Wann & Lewiston, Idaho Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71137

PLACE OF DEATH
County of Nez Perce
City of

Registration District No. 128
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wa-win-ma-tson-my (Mary Davis) 112

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE Indian 4/4
5. Single, Married, Widowed, or Divorced (write the word) Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE about 75 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant C. Bronchean
(Address) Culdesac Idaho

15. Filed March, 1930. George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-26-, 1930, to , 19
that I last saw her alive on 2-26-, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Gastro-Enteritis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
3/4, 1930, (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: About 6 miles East of Culdesac Id. Date of Burial: 3/6 1930

20. Undertaker: Brower-Dunn C. Lewiston Idaho Address

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71138

PLACE OF DEATH

County of Nez Perce.
City of Lewiston. (Orchards).
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. Lewiston Orchards.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel Gertrude Huggins.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. Huggins.

6. DATE OF BIRTH (month, day and year) Mar. 22nd. 1889.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41.	3.	22.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Idaho.

PARENTS

10. NAME OF FATHER J. L. Armstrong.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va.
12. MAIDEN NAME OF MOTHER Mary J. Lowmiller.
13. BIRTHPLACE OF MOTHER (city or town) Kansas City, (State or Country) Missouri.

14. Informant
(Address) Lewiston, Idaho.

15. Filed 6-18-30 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Primary Pneumonia
Complications Bronchitis
Sarcoma of right breast
Contributory Carcinoma
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C W Shaff, M. D.
6/16/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	6/16/30. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Scott

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71139

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No. 1609
Local Registrar's No.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME John Wesley Brubaker.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 11th, 1859.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70.	6.	3.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Peter Brubaker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Margaret Hallman.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant .....
(Address) Lewiston, Idaho.

15. Filed 6-18 1930 H. M. Lyle. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 14th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1930, to June 14, 1930
that I last saw him alive on June 14, 1930
and that death occurred, on the date stated above, at 9:30 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) R. T. Scott, M. D.
6/15/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	19 6/15/30.
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71140

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 2003

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Eliza J. Brisson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Brisson

6. DATE OF BIRTH (month, day and year) July 1 - 1864

7. AGE Years 65 Months 11 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10. NAME OF FATHER James Page.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oklahoma

12. MAIDEN NAME OF MOTHER — Elliott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Fred Brisson

(Address) 0106 - 29th St Lewiston

15. Filed 7-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to June 19, 1930 that I last saw her alive on June 19, 1930 and that death occurred, on the date stated above, at 9 p m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Paul G. Harvey M. D.

June 20, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho

Date of Burial June 21 1930

20. Undertaker Vassar Mortuary Inc Address Lewiston

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7114

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No. 1012
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Gannett.

(a) Residence. No. ..... St. Clarkston, Washington.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16th, 1912.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
18.	-0-	-5-.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Highschool student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Leupp.
(State or country) Arizona.

PARENTS

10. NAME OF FATHER E. A. Gannett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Constance L. Field.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant E. A. Gannett
(Address) Clarkston, Washington.

15. Filed 6-23, 1930 J. M. Lyle. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21st, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 26, 1930
that I last saw him alive on June 21, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) ..... yrs. ..... mos. 9 ds.
CONTRIBUTORY (Secondary) influenza

(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
6/21/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	6/24/30. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71142

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1909
Local Registrar's No. 164
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas McCarthy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 19th 1846

7. AGE	Years	Months	Days	If LESS than 1 day,
	83	9	5	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10. NAME OF FATHER Bernard McCarthy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Mary McCaele
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Resids at Hospital St Joseph
(Address) Lewiston Idaho

15. Filed June 26 1930 F. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from for [illegible] Grant, 19..., to ..., 19...
that I last saw h[illegible] alive on June 24, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Senility
..... (duration) yrs. mos. ds.
CONTRIBUTORY Fract Hip
(Secondary)
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) F. M. Lyle M. D.
6-30, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho.	6/25 1930
20. Undertaker Dassar Mortuary Inc	Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71143

Registration District No. 96

Primary Registration District No. 6009

Local Registrar's No.

PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. St. Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward F Sodorff

(a) Residence. No. 411 St. Johnson Wash

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25 - 1923

7. AGE	Years	Months	Days	If LESS than 1 day,
	7	5	4	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pullman Wash

PARENTS

10. NAME OF FATHER Chas Sodorff

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington Switzerland

12. MAIDEN NAME OF MOTHER Jennie Walker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Chas Sodorff

(Address) Johnson Wash

15. Filed 7-1, 1930 J. M. Lytle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to June 29, 1930

that I last saw him alive on June 28, 1930

and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Otitis media

(duration) yrs. 1 mos. 14 ds.

18. Where was disease contracted if not at place of death? Johnson Wash

Did an operation precede death? Yes Date of June 3-30

Was there an autopsy? No

What tests confirmed diagnosis? Staph & Pneumococcus

(Signed) Paul D Johnson M. D.

June 30, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Mos Cem Ida	

20. Undertaker Vassar Address Lewiston

RECEIVED JUL 9 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
71147

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Ft. Lapwai Indian Agency or Village Genesee Vicinity or
City Lapwai, Idaho. No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Agatha Fogarty Dellesage

(a) Residence. No. Genesee St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	1/4 Nez Perce Indian	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Dellesage

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	49	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS
10 NAME OF FATHER John Fogarty
11 BIRTHPLACE OF FATHER (city or town) Whitemans
(State or country)
12 MAIDEN NAME OF MOTHER Louise Thompson
13 BIRTHPLACE OF MOTHER (city or town) Lapwai
(State or country) Idaho

14 Informant Lewiston Morning Tribune
(Address) Lewiston, Ida.

15 Filed 1/5, 1930 [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from
---, 19---, to ---, 19---,
that I last saw h--- alive on ---, 19---,
and that death occurred, on the date stated above, at ---m.
The CAUSE OF DEATH* was as follows:
Not Known -

---(duration) --- yrs. --- mos. --- ds.
CONTRIBUTORY (SECONDARY) ---
---(duration) --- yrs. --- mos. --- ds.

18 Where was disease contracted if not at place of death? ---
Did an operation precede death? --- Date of ---
Was there an autopsy? ---
What test confirmed diagnosis? ---
(Signed) ---, M. D.
---, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lapwai Cemetery	Jan. 7. 1930
20 UNDERTAKER	ADDRESS
Brower-Nann Co.	Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 66

11—2184 GOVERNMENT PRINTING OFFICE

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

7114

1 PLACE OF DEATH
County Lewis State Idaho Registered No. 7
Township Ft. Lapwai Indian Agency or Village Kamiah Precinct or
City Lapwai Idaho No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Sam Peck

(a) Residence. No. Kamiah St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
		3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS

10 NAME OF FATHER Sam Peck

11 BIRTHPLACE OF FATHER (city or town) Kooskia
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Jennie Frank

13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Sam Peck Father
(Address) Kamiah, Ida.

15 Filed 1/12, 1930 L. M. Maxwell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Jan. 12 1930
20 UNDERTAKER	ADDRESS
Geo. W. Tenney	Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1—200 d
V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

7114 9

1 PLACE OF DEATH
County Lewis State Idaho Registered No.
Township Ft. Lapwai Indian Agency or Village Kamiah Vicinity or
City Lapwai, Idaho No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Abel Newton

(a) Residence. No. Kamiah St., Ward. 100a
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	4/4 Nez Perce Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Thompson

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Idaho

PARENTS

10 NAME OF FATHER Wah-pete

11 BIRTHPLACE OF FATHER (city or town) Nezperce
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Tickarley

13 BIRTHPLACE OF MOTHER (city or town) Nez Perce Res.
(State or country) Idaho

14 Informant Susie Minnie Newton-daur
(Address) Kamiah, Ida.

15 Filed 1/17/, 1930 A M Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ....., M. D.

....., 19 (Address) .....

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Jan. 18 1930

20 UNDERTAKER The Kamiah Funeral Home ADDRESS Kamiah

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every Item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 15

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

1 PLACE OF DEATH
County Clearwater State Idaho Registered No. 5
Township Ft. Lapwai Indian Agency or Village Ahsahka, Vicinity or
City Lapwai, Idaho. No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Oscar Wheeler #2

(a) Residence. No. Ahsahka, Ida St., Ward. 1a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 19[illegible]

7 AGE: Years 10 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ahsahka
(State or country) Idaho

PARENTS
10 NAME OF FATHER Harry Wheeler
11 BIRTHPLACE OF FATHER (city or town) Ahsahka
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Nellie James
13 BIRTHPLACE OF MOTHER (city or town) Stites
(State or country) Idaho

14 Informant Harry Wheeler - Father
(Address) Ahsahka, Ida

15 Filed Feb. 8, 1930 L. A. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7" 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ....., M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Ahsahka Cemetery
DATE OF BURIAL: Feb. 8 1930

20 UNDERTAKER: Not Known
ADDRESS: —

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
Registered No. 7116 1

1 PLACE OF DEATH
County Clearwater State Idaho
Township Ft. Lapwai Indian Agency or Village Orofino Vicinity or
City Lapwai, Idaho No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED JUL 9 1930

2 FULL NAME Ray Moffett

(a) Residence. No. Orofino, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

174

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	1/2 Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 1930

7 AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah Idaho
(State or country)

PARENTS
10 NAME OF FATHER Johnnie Moffett
11 BIRTHPLACE OF FATHER (city or town) Kamiah Idaho
(State or country)
12 MAIDEN NAME OF MOTHER Delisle Moffett
13 BIRTHPLACE OF MOTHER (city or town) Kamiah Idaho
(State or country)

14 Informant Lewiston Morning Tribune
(Address) Lewiston, Ida.

15 Filed 7/10/, 1930 [signature] REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9" 1930

17 I HEREBY CERTIFY, That I attended deceased from ----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:
Accident - Died from burns received in fire which destroyed home, while parents were away
---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY (SECONDARY) ----------
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? ----------
Did an operation precede death? ---------- Date of ----------
Was there an autopsy? ----------
What test confirmed diagnosis? ----------
(Signed) ----------, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Feb 11 1930
20 UNDERTAKER	ADDRESS
W. A. Show	Orofino

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 98

2 #6

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments; it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid;* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of -------- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

11—3184

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Register (Birth and Death)
Census Roll.
Degree of Blood.
Annuity Roll.
Allotment Record.
Indian Money Ledger (Deaths)

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

71152

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Ft. Lapwai Indian Agency or Village Lapwai or
City Lapwai, Idaho No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Popstowekartsat

11a

(a) Residence. No. Lapwai, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE 4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ellenwood

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years 92 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reserve
(State or country) Idaho

PARENTS
10 NAME OF FATHER Tak-kaats-mas
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) "
12 MAIDEN NAME OF MOTHER Tsim-mo
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) "

14 Informant Corbett B. Dwyer Clerk
(Address) Lapwai, Idaho

15 Filed Feb 11, 1930 L. A. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
~~Not known~~
Influenzal Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Lapwai Cemetery
DATE OF BURIAL Feb. 10 1930

20 UNDERTAKER Brower-Wann Co.
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

11—8184 GOVERNMENT PRINTING OFFICE

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED JUL 9 1930

71153

1 PLACE OF DEATH
County Lewis State Idaho Registered No.
Township or Village Kamiah Vicinity or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rebecca Blackeagle Parsons

31

(a) Residence. No. Kamiah, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Mallikan Parsons

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE: Years 48 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Norton Blackeagle
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Ah la lim we nun
13 BIRTHPLACE OF MOTHER (city or town) Nezperce
(State or country) Idaho

14 Informant Corbett B. Lawyer - Clerk
(Address) Lapwai, Ida

15 Filed Mar. 11, 1930 L. A. Macrodd
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10" 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unable to say
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Kamiah Cemetery
DATE OF BURIAL: Mar. 11 1930

20 UNDERTAKER: Kamiah Funeral Home
ADDRESS: Kamiah

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
7115 54

RECEIVED JUL 9 1930

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township ____ or Village Gifford & Vicinity or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Zackery

(a) Residence. No. Gifford St., ____ Ward.
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

20-B

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Gifford
(State or country) Idaho

PARENTS

10 NAME OF FATHER Louis Zackery
11 BIRTHPLACE OF FATHER (city or town) Plummer
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Iva Lott
13 BIRTHPLACE OF MOTHER (city or town) Gifford
(State or country) Idaho

14 Informant John C. Ellingwood
(Address) Gifford, Idaho

15 Filed 3/17, 1930 W. M. Maxwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1930

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h[illegible] alive on March 17, 1930, and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Cause of death unknown

____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____

____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) ____, M. D.

, 19 (Address) ____

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Private Family Cemetery	3/18/ 1930
20 UNDERTAKER	ADDRESS
Brown-Varner Co.	Lewiston

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 66

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71165

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township RECEIVED JUL 9 1930 or Village Lapwai Vicinity or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Carrie Parsons Luhhouse 31
(a) Residence. No. Lapwai, Ida. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Luhhouse

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years 73 Months Days If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER Obee Parsons
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Rev. Starr J. Maxwell
(Address) Lapwai Ida

15 Filed 4/13/, 1930 L. A. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12" 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw her alive on April 12, 1930,
and that death occurred, on the date stated above, at 4:50 p.m.
The CAUSE OF DEATH* was as follows:
Paralysis and Pulmonary Tuberculosis
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Lapwai Cemetery
DATE OF BURIAL April 14 1930

20 UNDERTAKER Brower-Wann Co
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71157

1 PLACE OF DEATH
County Lewis State Idaho Registered No.
Township RECEIVED JUL 9 1930 or Village Kamiah or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry Hayes A1104 1365

(a) Residence. No. Kamiah St., Ward. 1000
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE 4/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maria Moffett

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Wees loh boots tse tsin
11 BIRTHPLACE OF FATHER (city or town) Kamiah
(State or country) Ida.
12 MAIDEN NAME OF MOTHER Deborah Hayes
13 BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or country) Idaho

14 Informant Corbett B. Lawyer-Clerk
(Address) Lapwai, Ida

15 Filed 4/18/, 1930 L. M. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. H. Bryan, M. D.
, 19 (Address) Kamiah, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Kamiah Cemetery
DATE OF BURIAL April 19 1930

20 UNDERTAKER Geo W. Trenary
ADDRESS Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1—209 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71159

PLACE OF DEATH
County of Ada
City of Malad

Registration District No. 26
Primary Registration District No. 3064 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME George Fredrick McKay
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 25
7. AGE Years Months Days 2 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Malad Idaho

PARENTS
10. NAME OF FATHER George Stuart McKay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Idaho
12. MAIDEN NAME OF MOTHER Alice Sparks
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ogden Utah

14. Informant (Address) [illegible]

15. Filed 6/30 1930 J. M. Kerns Registrar
By Carmen Davis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 27, 1930
that I last saw him alive on June 27, 1930
and that death occurred, on the date stated above, at 10.30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature (8 mo) patent foramen ovale.
Imperforate anus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation for imperforate anus high up successful
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June 26 30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) V. P. Gant, M. D.
June 27, 1930 (Address) Malad, Ida.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial June 2[illegible] 19[illegible]

20. Undertaker D. C. Johnson
Address Burley Ida

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71160

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.) 10
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Roby Clyde Thomas

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov-30 1919

7. AGE Years 10 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. John Idaho

PARENTS
10. NAME OF FATHER Roby Clyde Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Rhonda Ellen Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. John Idaho

14. Informant Amalyle M. Jones
(Address) R.F.D. #1 Malad Ida

15. Filed 6/30, 1930. J. M. Kerns Registrar
By Carmen Davis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to June 21, 1930
that I last saw him alive on June 21, 1930
and that death occurred, on the date stated above, at 2 a.m. m.
The CAUSE OF DEATH* was as follows:
Diphtheria
(Dr. called June 18 with diagnosis of diphtheria but antitoxin not given for 4 days) (duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Acute nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phtest
(Signed) V. P. Garst, M. D.
June 23, 1930 (Address) Malad, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St. John Ida
Date of Burial June 22 1930

20. Undertaker J. Guy Hensar
Address Malad Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71161

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

112

2. FULL NAME Ephrian Edward Jones
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Jones.

6. DATE OF BIRTH (month, day and year) June-10-1861

7. AGE Years 69 Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wales.

PARENTS
10. NAME OF FATHER Zephaniah Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.
12. MAIDEN NAME OF MOTHER Caroline
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant Mrs Vern Peck
(Address) Ogden Ut.

15. Filed 6/30, 1930 J. M. Kerns Registrar
By Carmen Davis

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9, 1930, to June 10, 1930
that I last saw him alive on June 9, 1930
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Acute indigestion
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
6/12, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ct. John Oder — Date of Burial: June 13 1930

20. Undertaker: J. Guy Benson — Address: Malad Ca

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71162

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Owyhee
City of near Crane Falls. Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. 56

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nancy Elizabeth Wilson

(a) Residence. No. Pleasant Valley St. Idaho Owyhee Co.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Grant Wilson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) —

14. Informant (Address) Grant Wilson Mt. Home Idaho

15. Filed June 30, 1930 W J Eikenbush Registrar.
July 2

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage Uterine,
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Flu
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Pleasant Valley
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Wm. J. Eikenbush & Coroner, M. D.
June 30, 1930 (Address) Grand View

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home Ida.	6/24 1930
20. Undertaker G. S. Zacher	Address Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71163

PLACE OF DEATH

County of Owyhee

City of New Bruneau Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. 5-5-

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** Robert M. Adams.

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widower

6. DATE OF BIRTH (month, day and year) Oct 26-1856

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER John Quincy Adams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓

14. Informant (Address) G. W. Adams. Bruneau Idaho

15. Filed July 2/30, 19..... W J Erkenbeck Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1st, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1930, to May 29, 1930
that I last saw him alive on May 29, 1930
and that death occurred, on the date stated above, at 11 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic interstitia
Nephritis
mitral insufficiency
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Wm J Erkenbeck, M. D.
June 30, 1930 (Address) Grand View

19. Place of Burial, Cremation, or Removal: Bruneau Ida. — Date of Burial: 6/3 1930

20. Undertaker: G. S. Zacher — Address: Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71164

PLACE OF DEATH
County of Oyhee
City of Homedale

Registration District No. 3
Primary Registration District No. 2006
Local Registrar's No. 68
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vera Leona Carson
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 12 1907

7. AGE Years 22 Months 8 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oakley Ida

PARENTS

10. NAME OF FATHER O T Carson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Cty Utah

12. MAIDEN NAME OF MOTHER Ida E Bates

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tooele Utah

14. Informant (Address) O T Carson Homedale Ida

15. Filed 6-10-, 1930. John H. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7-30, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 4, 1930
that I last saw her alive on June 3, 1930
and that death occurred, on the date stated above, at — m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
Stretococcus viridans

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab
(Signed) Robert E Talbot, M. D.
June 10, 1930 (Address) Wilder

19. Place of Burial, Cremation, or Removal Canyon Hill Cemetery Boehlar Lawn
Date of Burial 6-10-30

20. Undertaker Paul L. Case
Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71165

PLACE OF DEATH
County of Payette
City of Near Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 19
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Bower
(a) Residence. No. Mentira St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If ~~married, widowed~~, or divorced ~~HUSBAND~~ of (or) WIFE of J. A. Bower

6. DATE OF BIRTH (month, day and year) Mar 31, 1868

7. AGE Years 62 Months 2 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER C. Plum
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ ✓
12. MAIDEN NAME OF MOTHER Catherine Hinkle
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) J. H. Adair Payette

15. Filed June 14, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 19..., to June 12, 1930
that I last saw her alive on June 11, 1930
and that death occurred, on the date stated above, at 1:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocardial degeneration

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Chas E Palmer, M. D.
June 14, 1930 (Address) Ontario Ore

19. Place of Burial, Cremation, or Removal: Riverside Cem Payette
Date of Burial: June 14 1930

20. Undertaker: J. H. Adair
Address: Paterson Furn Co Payette

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71166

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 18
(No.) 48B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrta A Douglas
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Widowed.

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of ~~(or)~~ WIFE of A C Douglas

6. DATE OF BIRTH (month, day and year) Aug 26 1850

7. AGE Years 79 Months 9 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER John M Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓ ✓
12. MAIDEN NAME OF MOTHER Susan Purdy
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓ ✓

14. Informant (Address) J H Adair Payette Ida

15. Filed June 10, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to June 8, 1930
that I last saw her alive on June 7, 1930
and that death occurred, on the date stated above, at 3:00 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) About one year yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) O.H. Avery, M. D.
June 9, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal Morris Hill Boise Date of Burial June 10 1930

20. Undertaker J H Adair Address Peterson Furn Co Payette

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 30 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7116[illegible]

County of Payette
City of New Plymouth
Registration District No. 5
Primary Registration District No. 1009
Local Registrar's No. 5

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Ann Lewis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Lewis

6. DATE OF BIRTH (month, day and year) Apr 18 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59		18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Lowell Mifflin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Celia Morgan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant C E Lewis
(Address) New Plymouth Ida

15. Filed May 10, 1930 Wm J Drysdale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to May 9 1930
that I last saw h[illegible] alive on May 9, 1930
and that death occurred, on the date stated above, at 8 30 a.m.
The CAUSE OF DEATH* was as follows: Carcinoma, of Sigmoid

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos few ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy

(Signed) Wm J Drysdale, M. D.
5-10-, 1930 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth Ida	May 11 1930
20. Undertaker	Address
Glenn C Landon	Payette Ida

RECEIVED JUN 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71168

PLACE OF DEATH

County of Payette
City of Fruitland

CERTIFICATE OF DEATH

Registration District No. 51
Primary Registration District No. 2130 Local Registrar's No. 3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Myrtle A Hooley

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

7 1/2

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of L G Hooley

6. DATE OF BIRTH (month, day and year) May 25-1875

7. AGE Years 55 Months — Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10. NAME OF FATHER John Helser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind
12. MAIDEN NAME OF MOTHER Elizabeth Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind

14. Informant (Address) L. G. Hooley Fruitland

15. Filed June 22, 1930 Mrs Wm 2 Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1930, to June 20, 1930
that I last saw her alive on June 20, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) W J Weese M. D.
June 22, 1930 (Address) Ontario, Ore

19. Place of Burial, Cremation, or Removal New Plymouth Date of Burial June 22 1930

20. Undertaker Peterson Furn Co T H Adair Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71169

PLACE OF DEATH

County of Power

City of American Falls, Ida.

Registration District No. 33

Primary Registration District No. 2072

Local Registrar's No. 11

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Frank R. Barnard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Barnard

6. DATE OF BIRTH (month, day and year): Apr. 18, 1870

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	2	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Brigham, Utah

PARENTS

10. NAME OF FATHER: Laconius Barnard

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Maria I Rudd

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Glenn F. Barnard

(Address) American Falls, Idaho.

15. Filed June 24, 1930. Gwenen Nott, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930 to June 22, 1930

that I last saw him alive on June 22, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cancer of Pancreas

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

6-24, 1930 (Address) Am Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I O O F Cemetery. Date of Burial: 6-24 1930

20. Undertaker: Am Davis Am Falls Ida. Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7190

PLACE OF DEATH
County of Shoshone
City of Kellogg, Ida

Registration District No. 12-3
Primary Registration District No. 2201

Local Registrar's No. 38

(No.) 161a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Kilimanns

(a) Residence. No. 5 Mill St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of Mary Kilimann
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10, 1878.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	11	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Samuel Kilimanns
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No Information Germany
12. MAIDEN NAME OF MOTHER No Information
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) No Information

14. Informant Mrs Mary Kilimanns
(Address) 5 Mill Ave. Kellogg, Ida

15. Filed June 30, 1930 Mrs. Helen M Bride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to June 11, 1930
that I last saw h~~im~~ alive on June 11, 1930
and that death occurred, on the date stated above, at 12:20 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
Asthma (duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Geo. H. Kennett M. D.
June 12, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	6/14/30
20. Undertaker	Address
M E Chamberlin	Kellogg Ida.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71171

PLACE OF DEATH
County of Shoshone
City of Masonia

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

2. FULL NAME James Henry Heatherly

(a) Residence. No. ..... St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora A. Heatherly Dec

6. DATE OF BIRTH (month, day and year): May 18th 1862

7. AGE: Years 68 | Months | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): None.
(c) Name of employer: none

9. BIRTHPLACE (city or town) (State or country): Parkersburg W. Va.

PARENTS
10. NAME OF FATHER: James Heatherly
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wood Co. W. Va
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know.

14. Informant: Edward C. Warren
(Address) Masonia Idaho.

15. Filed June 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 9, 1930
that I last saw him alive on June 9, 1930
and that death occurred, on the date stated above, at 4.35 P. m.
The CAUSE OF DEATH* was as follows:
Jaundice End Heart trouble.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no.
What test confirmed diagnosis? .....
(Signed) T. R. Mason, M. D.
6/10, 1930 (Address) Kellogg, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Castleton, Colo. | Date of Burial: 19

20. Undertaker: M. C. Shanahan | Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7172

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

101a

2. FULL NAME Robert Hellickson

(a) Residence. No. 707 North Howard St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M[redacted]

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Ida Hellickson

6. DATE OF BIRTH (month, day and year) 3-1-86

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43 —	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Mining
(c) Name of employer: Bunker Hill & Sullivan M. & C. Co.

9. BIRTHPLACE (city or town) (State or country): Grasmark Sweeden

PARENTS

10. NAME OF FATHER: John Hellickson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Grasmark Sweeden

12. MAIDEN NAME OF MOTHER: Nickolina

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Grasmark Sweeden

14. Informant: Mrs. Ida Hellickson
(Address): Kellogg Ida

15. Filed June 30, 1930 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 7, 1930
that I last saw him alive on June 7, 1930
and that death occurred, on the date stated above, at 7:15 P. m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
"Flu" (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Geo. H. Kennett, M. D.
June 11, 1930 (Address) Geo. H. Kennett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery	6/10 1930
20. Undertaker: M. C. Thurber	Address: Kellogg Idaho

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71173

PLACE OF DEATH

County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. Wardner Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

31

2. FULL NAME ~~B~~ George Baictich

(a) Residence. No. Wardner, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 43 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Servia

PARENTS

10. NAME OF FATHER Baictich
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Servia
12. MAIDEN NAME OF MOTHER No inf.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Servia

14. Informant Joe Milich
(Address) Kellogg, Idaho

15. Filed June 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930 to June 7, 1930 that I last saw him alive on June 6, 1930 and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo H Kennett, M. D.
June 7, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairmount Spokane Wash. Date of Burial: June 10/30

20. Undertaker: M. C. Thornhill Address: Kellogg Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71194

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 32

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Aaron Eva

(a) Residence. No. 815 McKinley Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Beatrice M. Eva

6. DATE OF BIRTH (month, day and year): 1876 Dec 31st

7. AGE: 54 Years 3 Years | Months 5 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): Mining
(c) Name of employer: B. H. S. Mining Co

9. BIRTHPLACE (city or town) (State or country): Camborne England

PARENTS

10. NAME OF FATHER: Harry Eva

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Camborne Cornwall Eng

12. MAIDEN NAME OF MOTHER: Elizabeth Carter

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pinpoints Camborne Cornwall Eng

14. Informant: Beatrice Eva
(Address): Kellogg - Ida -

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to June 1st, 1930, that I last saw him alive on May 28th, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis & Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) W. C. Lindsay, M. D.

6/3, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood
Date of Burial: June 4/30 19

20. Undertaker: M. C. Sharkie
Address: Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7119

Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 8

PLACE OF DEATH
County of Teton
City of Driggs

(No.) 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ann Josephine Nelson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) May 13 - 1844

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85	9	15	—

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home as
(b) General nature of industry, business, or establishment in which employed (or employer) Daughter
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pittsburg Penn

PARENTS

10. NAME OF FATHER David Evans
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Sarah Manthleas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant David Nelson
(Address) Marysville, Idaho

15. Filed 4 - 9 - 1930 Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Died during night

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Martha Marker Register M. D.
4 - 1 - 1930 (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bear Lake, Idaho	4-9 1930

20. Undertaker Lewis Kiser Address Ashton, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7179

PLACE OF DEATH

County of Teton
City of Driggs

Registration District No. 77
Primary Registration District No. 2176

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary ~~Ann~~ Hanna 90

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 16-1859

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home of
(b) General nature of industry, business, or establishment in which employed (or employer) daughter
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Madison Wis

PARENTS

10. NAME OF FATHER G. J. Flemming
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Ann High
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Jeanette C. Hanna
(Address) Driggs Idaho

15. Filed 6-20-, 1930. Martha Markin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-17, 1930, to 6-15, 1930
that I last saw her alive on 6-15, 1930
and that death occurred, on the date stated above, at 5:00 P. m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of heart

(duration) yrs. Suddenly mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 1 yrs. 3 mos. 16 ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) G. J. Parkinson, M. D.
6-17, 1930 (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clawson. Idaho	6-18- 1930

20. Undertaker — Address —

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71180

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

41

2. FULL NAME Gordon R. Erbland
(a) Residence. No. Reed Apt. Shoshone St North
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Vada Erbland

6. DATE OF BIRTH (month, day and year): May 22 1904

7. AGE: Years 26, Months 1, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS
10. NAME OF FATHER: George Erbland
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: La Fonda Gordon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill.

14. Informant: George Erbland
(Address) Twin Falls Ida.

15. Filed July 9th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to June 26, 1930, that I last saw him alive on June 26, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Septicemia melitensis

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary): Endocarditis chronic

(duration) several yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Unknown.
Did an operation precede death? No. Date of — — —
Was there an autopsy? No.
What test confirmed diagnosis? Clinical and laboratory findings.
(Signed) N. F. Passer, M. D.
June 28, 1930. (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: June 28 1930

20. Undertaker: P. J. Grossman
Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7382

PLACE OF DEATH
County of Twin Falls. Registration District No. 37
City of Twin Falls. Primary Registration District No. 2086
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Fehrenbacher. 68 c

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept. 2-1877.
7. AGE: Years 52 | Months 9 | Days 20 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith.
(b) General nature of industry, business, or establishment in which employed (or employer): Employer.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Ill.

PARENTS
10. NAME OF FATHER: Jos. Fehrenbacher.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Mary
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Mrs Cora Fehrenbacher
(Address): Filer, Idaho
15. Filed July 9th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 22 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to June 30, 1930
that I last saw him alive on June 22, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Fractured cervical vertebrae
in auto-accident.
Instant death yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) T. A. Wright, M. D.
June 22 1930 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Date of Burial: June 26 1930
20. Undertaker: F. E. Drake Address: Twin Falls

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7198

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Richard Hughes

(a) Residence. No. Twin Falls Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	6		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Missouri
(State or country)

PARENTS

10. NAME OF FATHER Eugene Hughes
11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)
12. MAIDEN NAME OF MOTHER Ruth Bybee
13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Eugene Hughes
(Address) Twin Falls Ida.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — , 19— , to — , 19— that I last saw h— alive on — , 19— and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning in Lateral 2 Miles West of Feler. Dam about 11-30 A.M. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) died Unattended (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Eyesight

(Signed) F. L. Drake Coroner, M.D.

June 20, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	6/21 1930
20. Undertaker	Address
White Mortuary Inc.	Twin Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71184

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

161a

2. FULL NAME Marjorie Smith
(a) Residence. No. 135 64 West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe md
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 18/30
7. AGE Years — Months — Days — If LESS than 1 day, 15 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Idaho
PARENTS
10. NAME OF FATHER O.H. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass
12. MAIDEN NAME OF MOTHER Marjorie Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada
14. Informant O.H. Smith
(Address) Twin Falls
15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 18 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 17th, 1930, to June 17th, 1930
that I last saw her alive on June 17, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Premature 7 months.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? ~~Dr~~ Clinical
(Signed) H E Lamb, M. D.
June 19th 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hazelton
Date of Burial Jun 30 1930
20. Undertaker F E Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

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RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71185

PLACE OF DEATH
County Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

85

2. FULL NAME F. Mackie
(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 15/1883
7. AGE Years 47 Months 6 Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER Tom Mackie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Lydia Long
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.C.

14. Informant Mrs. Mackie
(Address) Filer.
15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930 to June 16, 1930
that I last saw h alive on June 16, 1930
and that death occurred, on the date stated above, at 3:00 P.m.
The CAUSE OF DEATH* was as follows:
Shock & injuries sustained in fall from roof of house. Fracture base of skull, fracture of left femur, Colles fracture left wrist etc. (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
6/17 (Signed) A. A. Newberry, M. D.
, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Date of Burial: June 20 1930
20. Undertaker: F. E. Drake Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7198

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 107
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Philip Lee Kelly

(a) Residence. No. ..... Fairfield ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15 30

7. AGE Years	Months	Days	If LESS than 1 day,
—	—	27	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER A C Kelly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Alice Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant A C Kelley
(Address) Fairfield Ida

15. Filed ....., 19..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 12, 1930
that I last saw h~~im~~ alive on June 12, 1930
and that death occurred, on the date stated above, at 1 p.m.
The CAUSE OF DEATH* was as follows:
Acute rhino-bronchitis
& Pneumonia

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Fairfield
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C Russell Weaver M. D.
June 13, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairfield — Date of Burial: June 1930
20. Undertaker H E Dirk — Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71187

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

74a

2. FULL NAME Lucinda Kenci pp
(a) Residence. No. Filer St. Dr Dwight
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Am 7/1847
7. AGE Years 83 Months 2 Days 3 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Wife
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Tenn
PARENTS
10. NAME OF FATHER Archabel Talley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Rachel Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn
14. Informant Laura Grout
(Address) Filer
15. Filed July 9th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1930 3-30
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to June 10, 1930
that I last saw her alive on June 9, 1930
and that death occurred, on the date stated above, at 3:30 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Arterio-sclerosis.
(duration) 30 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) F. A. Dwight M. D.
June 10, 1930 (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Date of Burial June 11 1930
20. Undertaker F. E. Sooke Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71188

PLACE OF DEATH
County of Twin Falls
City of Hansen

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Charles A Satterwhite

(a) Residence. No. Hansen 7 11 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola Satterwhite

6. DATE OF BIRTH (month, day and year)

7. AGE: 65 Years | Months: 1 | Days: 10 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Knoxville Tenn

PARENTS

10. NAME OF FATHER: Frank Satterwhite
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Knoxville Tenn
12. MAIDEN NAME OF MOTHER: Mary Knox
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Tenn

14. Informant: Mrs. Satterwhite
(Address) Hansen Ida

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 2 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from on June 2 1930, 19
that I last saw him alive on June 2, 1930
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Chas. R. Scott, M. D.
6/4/, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Jun 5 1930

20. Undertaker: F. C. Drake | Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7119

PLACE OF DEATH
County of Twin Falls
City of ..11.. ..1..

Registration District No. .....
Primary Registration District No. 1
(No. 320 3rd St. West)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

31

2. FULL NAME Fred Dunlap

(a) Residence. No. 320 3rd St. West St.
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jenette Dunlap

6. DATE OF BIRTH (month, day and year) Dec 20 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	5	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kans.

PARENTS

10. NAME OF FATHER William Dunlap
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Adaline Britt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kans.

14. Informant Mrs Jenette Dunlap
(Address) 320 3rd St. West city

15. Filed July 11, 1930 Bernice Lepper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to May 29, 1930
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 6:10 a m.
The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis Bilateral Involving the Larynx
(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Empyema Right +++
(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death? San Francisco Calif
Did an operation precede death? Yes Date of April 23 30
Was there an autopsy? No
What test confirmed diagnosis? X-ray - Jos M Scanlon
(Signed) Duncan L McDermid, M. D.
6-3-30, 19..... (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls — Date of Burial June 3 1930
20. Undertaker O P Goodman — Address Twin Falls

RECEIVED JUL 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71190

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101B

2. FULL NAME Samuel L. Palmer

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 25 / 1848

7. AGE 82 Years 4 Months 3 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant E. M. Palmer
(Address) Filer Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 28 (Day) 1930 (Year) 8.30

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Died Unatended following acute Pneumonia
(duration) — yrs. — mos. 3 ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? General
(Signed) T. C. Drake Coroner
May 29th, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Cemetery Date of Burial May 29 1930

20. Undertaker T. C. Drake Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 11 1930

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 3-7

Primary Registration District No. 10 85

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 7191

Local Registrar's No.

91 B

2. FULL NAME Antoine Guibert

(a) Residence. No. 219 - 3rd Ave N. St. (Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Guibert

6. DATE OF BIRTH (month, day and year) Jan 27-1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Businessman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paris France

PARENTS

10. NAME OF FATHER Antoine Guibert

11. BIRTHPLACE OF FATHER (city or town) (State or Country) France

12. MAIDEN NAME OF MOTHER Mathilde Honvon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Mrs. Maria Guibert

(Address) 219 - 3rd Ave N.

15. Filed Feb 5th, 1930 E. J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec — 1929, to Jan 1, 1930

that I last saw h— alive on Jan 1, 1930

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ordinary.

(Signed) H. W. Wilson, M. D.

Jan. 2, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	1-3 1930

20. Undertaker	Address
White Mortuary	Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71192

PLACE OF DEATH
County of Twin Falls
City of Buhl Ida

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Edwin Sherman Leland

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Hood Leland

6. DATE OF BIRTH (month, day and year) Nov 23rd 1872

7. AGE Years 57 Months 6 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Abstract of Title
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ottawa Ill.

PARENTS
10. NAME OF FATHER Sherman Leland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Near Ottawa Ill.
12. MAIDEN NAME OF MOTHER Ellen Louisa Louise Foote
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ida.

14. Informant (Address) Howard Leland Buhl

15. Filed June 21, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 20, 1930
that I last saw him alive on June 19, 1930
and that death occurred, on the date stated above, at 3.15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina pectoris

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. L. Berry M. D.
June 21 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida Date of Burial 6/22 1930

20. Undertaker L. J. Johnson Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71193

PLACE OF DEATH
County of Twin Falls
City of Buhl Ida

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Mary Abbl 159c
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. — yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓
6. DATE OF BIRTH (month, day and year) June 20-1930
7. AGE Years ✓ Months ✓ Days ✓ If LESS than 1 day, 7 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Buhl Ida.

PARENTS
10. NAME OF FATHER Edward Abbl
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minnesota.
12. MAIDEN NAME OF MOTHER Racheal Lyon
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Manitoba Can

14. Informant (Address) Edward Abbl Buhl Ida
15. Filed 6. 21, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 20, 1930
that I last saw her alive on June 20, 1930
and that death occurred, on the date stated above, at 8 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Micro Cephalic
7 hours Old.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R E Shurtz, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Buhl Ida
Date of Burial 6/21 1930
20. Undertaker L. J. Johnson
Address Buhl Ida

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71195

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Co. Hospital

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No. 179)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Frederick A. Carey

(a) Residence. No. Buhl St.
(Usual place of abode.)
Length of residence in city or town where death occured 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of E. M. Carey

6. DATE OF BIRTH (month, day and year) Dec 22nd 1890

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Milan Ills.

PARENTS

10. NAME OF FATHER Jacob Buches
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Barbara Knaus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant (Address) E. M. Carey

15. Filed May 11, 1930 J. H. Munkley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1930, to May 9, 1930
that I last saw her alive on May 9, 1930
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidentally burned.
T/A body surface

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical.

(Signed) J. H. Munkley, M. D.
May 11, 1930 (Address) Buhl Ida.

19. Place of Burial, Cremation, or Removal: Modesto, Cal. | Date of Burial: 19

20. Undertaker: L. D. Johnson | Address: Buhl Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7119

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Helen Fritcher

(a) Residence. No. Buhl Idaho St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos D Fritcher

6. DATE OF BIRTH (month, day and year): Sept 23 1884

7. AGE: Years 45 | Months 8 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mo

PARENTS

10. NAME OF FATHER: Robert Asquith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Md
12. MAIDEN NAME OF MOTHER: Mary Agnes Mrs Caples
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known Mo

14. Informant: Thos. D. Fritcher
(Address): Buhl Idaho

15. Filed June 4, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to June 1, 1930
that I last saw h[er] alive on June 1, 1930
and that death occurred, on the date stated above, at 12.55 P m.
The CAUSE OF DEATH* was as follows:

Acute dilitation of Heart.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Coronary Embolus
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of May 31-1930
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) J. H. Murphy, M. D.
June 4, 1930 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Buhl Cemetery — Date of Burial: 6/6 1930
20. Undertaker: Merville D Rugg — Address: Buhl Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A. 25 M. 1-19

RECEIVED JUN 23 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. St.)

File No. 71198

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Carr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1848 (Year)

7. AGE: 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Bloomfield Ohio

10. NAME OF FATHER: James Chinnock

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Harriett Owens

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) N. A. Carr.

(Address) McCall Ida.

15. Filed May 9 1930

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1930 (Year) 131

17. I HEREBY CERTIFY, That I attended deceased from April 23 1930, to May 8 1930, that I last saw her alive on 19, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Abdominal Dropsy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr U. S. Croff M. D.

19 (Address) McCall Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Idaho

DATE OF BURIAL: May 11 1930

20. UNDERTAKER: W. M. Bratton

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 15

Primary Registration District No.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71199

Registered No.

1. PLACE OF DEATH

County of Valley

City of Cabarton

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Marvin Tegarden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 27 (Day) 1930 (Year)

7. AGE: Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cabarton Idaho

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Iowa Iowa

12. MAIDEN NAME OF MOTHER: Lethe May Legerly

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Tegarden

(Address)

15. Filed 19 Stella Crim Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1930, to June 3 1930 that I last saw h-- alive on June 3 1930, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) 0 Yrs. 0 mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Roscoe B Ward M. D.

6/4 1930 (Address) Cascade

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho — DATE OF BURIAL: June 5 1930

20. UNDERTAKER: W. M. Bratney — ADDRESS: Cascade Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25/M. 1-19. RECEIVED JUL 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Cascade

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

File No. 71200

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Dealy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1852 (Year)

7. AGE: 78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Wheeling West ✓

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert Dealy

(Address)

15. Filed 19 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH: June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1 1927, to June 3 1930, that I last saw her alive on May 25 1930, and that death occurred on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary) Myocarditis

(Duration) 0 yrs. 3 mos. 0 ds.

(Signed) Roscoe C Ward M. D.

6/4 1930 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho

DATE OF BURIAL: June 4 1930

20. UNDERTAKER: Wm. M. Bratney by A. D. Robb

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13

Primary Registration District No.

File No. 71201

Registered No.

1. PLACE OF DEATH:
County of Valley
City of McCall Idaho
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	(Widower)

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
53 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Care Taker Sylvan Beach
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Mich

10. NAME OF FATHER
Unknown

11. BIRTHPLACE OF FATHER
(State or Country) ✓

12. MAIDEN NAME OF MOTHER
✓

13. BIRTHPLACE OF MOTHER
(State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Hall
(Address)

15.
Filed 19
Stella Cain
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1930 to June 5 1930
that I last saw h. alive on June 5 1930,
and that death occurred on the date stated above, at 1 20 P. M.

THE CAUSE OF DEATH* was as follows:
(R.W.) Incle-Jaun
(Duration) about Yrs. mos. 8 ds.
Contributory (Secondary) Nephritis —
(Duration) about 2 yrs. mos. ds.

(Signed) W. D. Chambers M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall Idaho
DATE OF BURIAL: June 6 1930

20. UNDERTAKER: Wm McBroney By W S Hoff
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71202

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

196

2. FULL NAME Mary Emma Van Fossen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Whp
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May 16 – 1918

7. AGE: Years 11 Months 11 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: Eugene Van Fossen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oak
12. MAIDEN NAME OF MOTHER: Iva Bowbeman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: Eugene Van Fossen
(Address): Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30th, 1930, to May 3rd, 1930
that I last saw her alive on May 3rd, 1930.
and that death occurred, on the date stated above, at 6:15 m.
The CAUSE OF DEATH* was as follows:
Shock following electrical burn on left arm right and left foot and face
..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of May 3-30
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) C. C. Conant, M. D.
5/4/30, 19.... (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery
Date of Burial: 5-5 1930

20. Undertaker: L. C. Northam
Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71203

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
Local Registrar's No. 25

(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Lund Moore

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Noel Moore

6. DATE OF BIRTH (month, day and year) Nov 22 1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Francis A Lund
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Margaret E. Wood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Noel Moore
(Address) Weiser Idaho

15. Filed June 11 1930 W. A. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Coroner Verdict. Death by shot wounds inflicted with 32 Colts S & W. revolver held by her own hand and fired with Suicidal intent (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Domestic Trouble
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) L. C. Northam Coroner M.D.
4-24-, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	4-26 1930

20. Undertaker	Address
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71204

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1810
Local Registrar's No. 24

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Bert L. Wilson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 20 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Adrian

PARENTS

10. NAME OF FATHER Samuel L. Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Anna Reader
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Norman Wilson
(Address) Weiser Ida

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19, 1930, to April 19, 1930
that I last saw h— alive on April 19, 1930
and that death occurred, on the date stated above, at 7.10 m.
The CAUSE OF DEATH* was as follows:
apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) L. L. Cannon, M. D.
4-19-30 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	Apr. 21 1930
20. Undertaker L. L. Northam	Address Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71205

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 10 10

Local Registrar's No. 23

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME William Lanning

(a) Residence. No. Poor Farm St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Mar. 15th 1839

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
91	—	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Trenton N. J.

PARENTS

10. NAME OF FATHER Jasper Lanning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. J.
12. MAIDEN NAME OF MOTHER Mary Buck.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Henry Lanning
(Address)

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 13, 1930, that I last saw him alive on April 13, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) W. R. Hamilton, M. D.
April 13th, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	4-15- 1930
20. Undertaker L. L. Northam	Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71206

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Marie Nestor Turner

(a) Residence. No. Oregon Side St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

148

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wh
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Guy Turner

6. DATE OF BIRTH (month, day and year) Nov 28

7. AGE Years 30 Months 4 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER George Nestor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Lola Belle Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant George Nestor
(Address) Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 10, 1930
that I last saw her alive on April 10, 1930
and that death occurred, on the date stated above, at 5:30 a m.
The CAUSE OF DEATH* was as follows:
Toxic Kidney of Pregnancy and Eclampsia
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ernesto Finney M. D.
4 22, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 4-12-1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Firing

DO NOT WRITE IN THIS SPACE
State File No. 71207

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

47

2. FULL NAME Jessie F Dutton
(a) Residence. No. 905 W 4 st St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Dutton

6. DATE OF BIRTH (month, day and year) Nov 21st 1888

7. AGE Years 41 Months 4 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS
10. NAME OF FATHER Albert S Dawson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va
12. MAIDEN NAME OF MOTHER Rebecca Murrell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Va

14. Informant Wm Dutton
(Address) Weiser. Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to Apr. 5, 1930
that I last saw her alive on Apr. 5, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Carcinoma Breast
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Metastasis Hepatic
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Microscopic
(Signed) Conrad S. Firing, M. D.
April 28, 1930 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 5-8-1930

20. Undertaker L. C. Northam — Address Weiser Ida

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71208

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1810
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

29

2. FULL NAME Alida Skonnord

(a) Residence. No. 604 West Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht.	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of B.O. Skonnord.

6. DATE OF BIRTH (month, day and year) July 8 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	7	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Worked in Laundry
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER John Lindgren
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Christine Gerden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant John Lindgren
(Address) Weiser Ida

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 15 -, 1930, to Mar 25 -, 1930
that I last saw her alive on Mar 25 -, 1930
and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F A Schmidt, M. D.
Mar 26, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Wallace Idaho	
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71209

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 8
Primary Registration District No. 1010
Local Registrar's No. 19

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar Estby

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widowed

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Lulu Anderson Estby

6. DATE OF BIRTH (month, day and year) Dec 24. 1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	5	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Ole Estby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs Rasa Lawson
(Address) Emmett - Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Found dead in bed had been dead about 10 hours
Heart Trouble
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. C. Northam Coroner
3-25-, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	3-25-1930
20. Undertaker L. C. Northam	Address Weiser Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

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RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71210

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1610

Local Registrar's No. 18

164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosina Raymond

(a) Residence. No. East Park St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widowed

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Lyman Raymond

6. DATE OF BIRTH (month, day and year) Nov. 18-1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	0	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Samuel Cook

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Mrs F. E. Buchanan
(Address) Weiser, Ida

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 21st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
March 14, 1930, to March 21, 1930
that I last saw her alive on March 19, 1930
and that death occurred, on the date stated above, at 11½ m.
The CAUSE OF DEATH* was as follows:
Senility

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. A. Schmid, M. D.
Mar 22, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	3-23 1930
20. Undertaker L. C. Northam	Address Weiser, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JUN 26 1930

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71241

Registration District No. 86

Primary Registration District No. 1016

Local Registrar's No. 17

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna T Wavrich

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

204

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Whp

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Wavrich

6. DATE OF BIRTH (month, day and year) March. 18-1861

7. AGE Years 69 Months 0 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10. NAME OF FATHER Henry Semans

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hungary

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hungary

14. Informant J. J. Wavrich
(Address) Weiser Ida

15. Filed June 11, 1930 W. R. Hamilton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw her alive on 1 Oct. 1929

and that death occurred, on the date stated above, at 12 a m.

The CAUSE OF DEATH* was as follows:

Blood Clot in heart
Died sudden

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Blood clot came from leg ulcers

..... (duration) 20 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) F. A. Schmitt, M. D.

3-19-, 1930 (Address) Weiser Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal [illegible] Cemetery — Date of Burial 3-2[illegible] 1930

20. U[illegible] L. C. [illegible] House — Address Weiser Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUN 26 1930

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71242

Registration District No. 86

Primary Registration District No. 1010

Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Britt Griffith

(a) Residence. No. Weiser Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Griffith

6. DATE OF BIRTH (month, day and year) Sept 22 - 1886

7. AGE 43 Years | Months 8 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Well Driller

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Tacoma
(State or country) Wash.

PARENTS

10. NAME OF FATHER James Griffiths

11. BIRTHPLACE OF FATHER (city or town) Texas
(State or Country)

12. MAIDEN NAME OF MOTHER Hollie

13. BIRTHPLACE OF MOTHER (city or town) Texas
(State or Country)

14. Informant Mrs Mary Griffiths
(Address) Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd, 1930, to June 4th, 1930 that I last saw him alive on June 4th, 1930 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Accidental - death due to embolism - from injury to Rectum

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. R. Hamilton, M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Helens, Ore. | Date of Burial 19

20. Undertaker L. C. Northam | Address Weiser Ida

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71243

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010

Local Registrar's No. 32

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lena Fifer Cozier

(a) Residence. No. Weiser Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Widowed

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Robert V Cozier

6. DATE OF BIRTH (month, day and year) Apr. 22 - 1864

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Thos Fifer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N Y

12. MAIDEN NAME OF MOTHER Matilda Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant A. O. Sutton
(Address) Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to May 27, 1930 that I last saw h~~er~~ alive on May 27, 1930 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma (Pylorectal of Stomach

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (?)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Seattle Wash

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) W. R. Hamilton M. D.

June 27, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Ida	19

20. Undertaker L. C. Northam | Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JUN 26 1930

7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71244

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1016
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

48 B

2. FULL NAME Nancy Jane Hancock
(a) Residence. No. 614 W Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: D. N. Hancock

6. DATE OF BIRTH (month, day and year): May 30. 1850

7. AGE: Years 79 | Months 11 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Georgia

PARENTS
10. NAME OF FATHER: John Price
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: D. N. Hancock
(Address): Weiser, Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to May 19, 1930
that I last saw her alive on May 19, 1930
and that death occurred, on the date stated above, at 1:30 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis & Mitral Insufficiency
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Anaemia
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ernest O. Finney M. D.
May 26, 1930 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery | Date of Burial: May 20 1930

20. Undertaker: L. C. Northam | Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED JUN 26 1930

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71215

Local Registrar's No. 30

101 B

2. FULL NAME Amanda Ellen Welch

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE Wht

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of George Welch

6. DATE OF BIRTH (month, day and year) July 26 - 1850

7. AGE Years 79 Months 9 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Ezra Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs Ada Soiling

(Address) Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to May 15, 1930

that I last saw her alive on May 15, 1930

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Hypostatic

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Pleurisy & Effusion

..... (duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Ernesto Finney M. D.

May 26, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Galloway Cemetery — Date of Burial 5-17 1930

20. Undertaker L. C. Northam — Address Weiser Ida

DEPARTMENT OF PUBLIC WEL...
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71246

PLACE OF DEATH
RECEIVED JUN 26 1930
County of Washington
City of Weiser

CERTIFICATE OF DEATH

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 29

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Richard Holt

(a) Residence. No. Poor Farm St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Whr	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 15 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	0	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Corvallis Oregon

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant County Poor Farm
(Address) Weiser, Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to —, 19—
that I last saw h— alive on May 10, 1930
and that death occurred, on the date stated above, at 11 A. m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No

(Signed) W. R. Hamilton M. D.
5/29/30, 19— (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	5-12-1930
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71247

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 96
Primary Registration District No. 1010
Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Millie Mary Kusy

(a) Residence. No. Cambridge Idaho St. 92
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph J Kusy

6. DATE OF BIRTH (month, day and year) May 20-1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	9	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) So. Dakota

PARENTS

10. NAME OF FATHER Chas B. Bouck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Anna Perrit
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Rudolph J. Kusy
(Address) Cambridge Idaho

15. Filed June 11, 1930. W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to May 18, 1930
that I last saw h[illegible] alive on May 18, 1930
and that death occurred, on the date stated above, at 3 6 m.
The CAUSE OF DEATH* was as follows:
Operated for tubercular tumor followed by Thrombosis of mesenteric artery.
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of May 13-30
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) F A Johnson, M. D.
May 19, 1930 (Address) Weiser, I.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	May 20 1930
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUN 26 1930

5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71218

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 27

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME W H. Lane

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Hospital Records
(Address) Weiser Idaho

15. Filed June 11, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14-30, 19, to May 8th, 1930
that I last saw h[illegible] alive on May 8th, 1930
and that death occurred, on the date stated above, at 1.30 a m.
The CAUSE OF DEATH* was as follows:
apoplexy.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. L. Summers, M. D.
5/9/30, 19 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	5-9-1930
20. Undertaker L. L. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71219

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 20
Primary Registration District No. 110
(No. [illegible])
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

14

2. FULL NAME Ancy Sullivan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 8 - 1882

7. AGE: 47 Years, Months 9, Days 22. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Coffeyville Kansas

PARENTS

10. NAME OF FATHER: Andrew J. Sullivan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Elizabeth Reynolds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs Eleanor M. Sullivan
(Address) Emmett Idaho

15. Filed July 14, 1930. W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to June 30th, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:
Rocky Mountain Spots Fever
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? McCall Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. R. Hamilton M. D.
July 31, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 7/3 1930

20. Undertaker: D Bucknum
Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71220

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 1000

Local Registrar's No. 27

164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertrand W. Wood

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Marie Wood

6. DATE OF BIRTH (month, day and year) July 31-1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10. NAME OF FATHER Gideon Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs Arthur Turnidge
(Address) Weiser Ida

15. Filed June 24, 1930 W. C. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to June 19, 1930
that I last saw h[illegible] alive on June 19, 1930
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:

Lithe absorption

(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of May 20 30
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. A. Marshall, M. D.
June 20, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Heelcrest Cemetery	6-22-1930

20. Undertaker	Address
L. L. Northam	Weiser

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71221

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

201

2. FULL NAME James P. Gray
(a) Residence. No. Mirrhead Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Clarisa Gray

6. DATE OF BIRTH (month, day and year) Dec 10-1846

7. AGE 83 Years | Months 6 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Driving Sprinkler Wagon
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Thomas Gray
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Clarisa Gray
(Address) Weiser Idaho

15. Filed June 23rd, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15th, 1930, to June 22, 1930
that I last saw him alive on June 22nd 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows: Toxemia following fracture of leg.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? None Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. R. Hamilton, M. D.
June 23rd, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial June 24 1930

20. Undertaker L. C. Northam | Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71292

Registration District No. 10
Primary Registration District No. 1010
Local Registrar's No. 37

PLACE OF DEATH
County of Washington
City of Weiser
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Nellie Linder

(a) Residence. No. Workmans Hospital St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. F. Linder

6. DATE OF BIRTH (month, day and year) Aug 6 - 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	9	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lehigh Idaho Idaho

PARENTS

10. NAME OF FATHER John Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Ada Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant J. W. Beckham
(Address) Weiser Idaho

15. Filed June 1 1930 W. T. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15, 1930, to May 31, 1930
that I last saw her alive on May 31, 1930
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. Beckham, M. D.
June 1, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sweet Creek Cemetery	6 - 2 - 1930
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71223

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 65
Primary Registration District No. 1010.
Local Registrar's No. 35

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME George T. Nuslein
(a) Residence. No. Union Oregon St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Millie Nuslein
6. DATE OF BIRTH (month, day and year) Nov 7 - 1863
7. AGE Years 66 Months 6 Days 24 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work John Nuslein
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER John Nuslein
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Barbara Bower
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs George T. Nuslein
(Address) Weiser Idaho.
15. Filed June 2nd, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 1st (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 31, 1930, to May 31, 1930
that I last saw him alive on May 31, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Thrombosis of Coronary artery.
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. W. Marshall, M. D.
June 2, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 6-3-1930
20. Undertaker L. C. Northam — Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 12 1930

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71234

Local Registrar's No. 36

131

2. FULL NAME Aurelia D. Dunsmoor

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of John Dunsmoor

6. DATE OF BIRTH (month, day and year) Oct. 25-1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant John Dunsmoor
(Address) Weiser Ida

15. Filed June 15th, 1930. W R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1929, 19 29, to June 8, 1930
that I last saw h-er alive on June 8, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral pressure

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W M Marshall, M. D.
June 14, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	6-16-1930

20. Undertaker	Address
L. B. Northam	Weiser Ida

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71225

PLACE OF DEATH
County of Franklin.
City of Weston.

Registration District No. 27
Primary Registration District No.
Local Registrar's No. 58

(No. Weston, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

18

2. FULL NAME Erastus Schvaneveldt.

(a) Residence. No. Weston, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mae Phillips Schvaneveldt.

6. DATE OF BIRTH (month, day and year) Mar. 29. 1870.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Stock Raiser.
(b) General nature of industry, business, or establishment in which employed (or employer) For Himself.
(c) Name of employer

9. BIRTHPLACE (city or town) Brigham,
(State or country) Utah.

PARENTS

10. NAME OF FATHER E.C.E. Schvaneveldt.
11. BIRTHPLACE OF FATHER (city or town) Denmark.
(State or Country)
12. MAIDEN NAME OF MOTHER Karna Toolson.
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Sweden.

14. Informant Mrs. Mae Phillips Schvaneveldt.
(Address) Weston, Idaho.

15. Filed 7-5, 1930 A. R. Quiley
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. 15. 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 14, 1930
that I last saw him alive on July 14, 1930
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:
Spotted Fever, Tick Bite

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Thos. B Holder, M. D.
July 16, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston, Idaho.	7-18 1930.
20. Undertaker M. W. Hendricks.	Address Preston, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 8 1930
PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71226

County of Franklin
City of Dayton.
Registration District No. 27
Primary Registration District No.
Local Registrar's No. 57
(No. Dayton, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Horace D. Taylor.

(a) Residence. No. Dayton, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 23. 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dayton, Idaho.

PARENTS

10. NAME OF FATHER John LeRoy Taylor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin, Idaho.
12. MAIDEN NAME OF MOTHER Melissa Smith.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lewiston, Utah.

14. Informant John LeRoy Taylor.
(Address) Dayton, Idaho.

15. Filed 8-5-, 1930. A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. (Month) 14. (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 —, 1930, to July 14, 1930
that I last saw him alive on July 13, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) 1 yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W. Staley M. D.
July 14, 1930 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dayton, Idaho.	July. 15. 1930.
20. Undertaker	Address
M. W. Hendricks.	Preston, Ida.

Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71228

PLACE OF DEATH
County of Franklin
City of Franklin
Registration District No. 27
Primary Registration District No.
Local Registrar's No. 56
(No. Franklin, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Hans Christenson Olsen.

(a) Residence. No. Franklin, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annette Olsen

6. DATE OF BIRTH (month, day and year) Jan. 12. 1855.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Rancher
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10. NAME OF FATHER Olof Olsen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.
12. MAIDEN NAME OF MOTHER Anna Scoroken.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant Mrs. Hans Christenson Olsen.
(Address) Franklin, Idaho.

15. Filed 8-5-30, 19.... A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. 5. 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to July 5, 1930
that I last saw h— alive on July 5, 1930
and that death occurred, on the date stated above, at 4:15 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(duration) 2 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Senile Gangrene
(duration) — yrs. 2 mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of June 27-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
July 6, 1930 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Franklin, Idaho.	
20. Undertaker M. W. Hendricks	Address Preston, Ida.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71229

PLACE OF DEATH
County of Franklin.
City of Preston.
Registration District No. 27
Primary Registration District No.
(No. Preston Hospitel.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 56

92

2. FULL NAME Ada Irene Keller.

(a) Residence. No. Mink Creek, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Urias Keller.

6. DATE OF BIRTH (month, day and year) July. 17. 1883.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bennington, Idaho.

PARENTS

10. NAME OF FATHER Hyrum Isiac Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Farmington, Utah.
12. MAIDEN NAME OF MOTHER Lucy Tippets.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Parie, Utah.

14. Informant Urias Keller.
(Address) Mink Creek, Idaho.

15. Filed 8-5-30 19... G. K. Carley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. (Month) 14 (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-12, 1930, to 7-14, 1930
that I last saw h. M alive on 7-13 1930
and that death occurred, on the date stated above, at 1230 a. m.
The CAUSE OF DEATH* was as follows:
Thrombosis of superior mesenteric artery
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. K. Carley, M. D.
, 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mink Creek, Idaho.	7-17.- 1930.
20. Undertaker Alvin Keller.	Address Rexburg, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71230

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 55

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME ~~Elizabeth~~ Wicklund

(a) Residence. No. 30 West 2nd So. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Albion Wicklund

6. DATE OF BIRTH (month, day and year) May 17, 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	1	19	hrs. or min.

8. OCCUPATION OF DECEASED At Home
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tina, Grand County Mo.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Albion Wicklund
(Address) Preston - Idaho

15. Filed 8-5-, 1930. G. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to July 6, 1930
that I last saw her alive on July 6, 1930
and that death occurred, on the date stated above, at 7 05 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) High blood pressure

Arteriosclerosis (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. W. Staley, M. D.

July 7, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Cemetery	19

20. Undertaker G. W. Lundquist Address Logan

PRINTED WITH UNFADING INK—THIS IS A PERMANENT RECORD
...formation should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71231

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Froman Grant Johansen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July I 1930

7. AGE Years Months Days If LESS than 1 day, 4 hrs. or min.

8. OCCUPATION OF DECEASED BABY
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Jacob G. Johansen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Laura P. Mitchel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ammon Idaho

14. Informant Jacob G Johansen
(Address) Preston Idaho

15. Filed 5-5-, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 1, 1930
that I last saw him alive on July 1, 1930
and that death occurred, on the date stated above, at 11:15 a m.
The CAUSE OF DEATH* was as follows:
Born at 6½ months of Gestation
(duration) yrs. mos. 4 hrs

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) G. W. Stater M. D.
July 1, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ammon Idaho Date of Burial July 2 30 19

20. Undertaker M. W. Hendricks Address Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 21 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71232

County of Fremont
Registration District No. 99
City of St. Anthony, Idaho
Primary Registration District No. 2177
Local Registrar's No. 340

(No.) 100a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tillie E. Mitchell

(a) Residence. No. St. Anthony, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
(or) WIFE of E. R. Mitchell

6. DATE OF BIRTH (month, day and year) Dec. 27th, 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	6	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dallas, Ill.

PARENTS

10. NAME OF FATHER Heborn Tilton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Main
Sarah A. Bond
12. MAIDEN NAME OF MOTHER Sarah A. Bond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y. State

14. Informant E. R. Mitchell
(Address) St. Anthony, Idaho.

15. Filed July 6th, 1930 W. M. Hansen Registrar W. M. Hansen

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26, 1930, to July 6, 1930
that I last saw her alive on July 6th 1930,
and that death occurred, on the date stated above, at 4:15 a. m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) Acute Articular Rheumatism
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Findings

(Signed) P. M. Kelly, M. D.
July 6th, 1930 (Address) St. Anthony, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverview St. Anthony	July 9-1930
20. Undertaker Ray St. Anthony	Address St. Anthony, Idaho.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

99

DO NOT WRITE IN THIS SPACE
State File No. 71233

PLACE OF DEATH

County of Fremont
City of St. Anthony
Registration District No.
Primary Registration District No. 2177
Local Registrar's No. 341
(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Edginton

(a) Residence. No. St. Anthony, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 11th, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	XX	XX	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Anthony, Idaho.

PARENTS

10. NAME OF FATHER: William Edginton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wilfird, Idaho.
12. MAIDEN NAME OF MOTHER: Blanch Young
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Twin Groves, Idaho.

14. Informant: William Edginton,
(Address): St. Anthony Idaho Route 2

15. Filed July 11-1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 11th, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1930 to July 11, 1930
that I last saw him alive on July 11th, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Premature Birth

(duration) yrs. mos. 30 min.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) P. M. Kelly, M. D.
July 11-1930, 19 (Address) St. Anthony, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilford Cemetery	July 11-1930

20. Undertaker	Address
St. Anthony	Idaho.

W. M. Hansen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 8 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gem
City of Sweet
(No. ..... St.)
Registration District No. .....
Primary Registration District No. 6
File No. 71234
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Levi Talley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 18 (Day) 1848 (Year)

7. AGE: 82 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Harrison Talley

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Hannah Smith

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Mrs Mary Leary

15. Filed 7/27 1930 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH: July (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
This was case of apoplexia - no doctor in attendance
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
7/27 1930 (Address) J. L. Reynolds Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C. D. Buckmeier — DATE OF BURIAL: 7/27 1930

20. UNDERTAKER: C. D. Buckmeier — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

RECEIVED AUG 8 1930

PLACE OF DEATH

County of Gem

City of Emmett

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 6

Primary Registration District No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71235

Local Registrar's No.

2. FULL NAME Louisa A. Grant

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widow

6. If married, widowed, or divorced — HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 12 - 1843

7. AGE: Years 86 | Months 11 | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER: David Garner

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: Polly Durfy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant (Address): C W Lake

15. Filed 6/21, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1929, to June, 1930, that I last saw h-- alive on April, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J L Reynolds M.D.

6/21, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 6/23 1930

20. Undertaker: O D Buckmaster — Address: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 8 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Emmett

Registration District No.

Primary Registration District No. 4

(No. ..... St.)

File No. 71236

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy A. Brownfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Oct 11 (Month) (Day) 1845 (Year)

7. AGE: 84 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: William Hoard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C O Brownfield

(Address) Black Rock Utah

15. Filed 7/30 1930

J H Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

204

16. DATE OF DEATH: July (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h...alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Sudden death was
possibly Angina attack

(Duration) Sudden yrs. mos. ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Reynolds M. D.

7/30 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 7/30 1930

20. UNDERTAKER: C D Bucknum

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71237

County of Ada

City of Emmett

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frances E. Hansen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 31 - 1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	8	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Union Utah

PARENTS

10. NAME OF FATHER E. F. Hansen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Ida Phillips

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant E. F. Hansen
(Address) Emmett Idaho

15. Filed 7/24, 1930 J. H. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 22, 1930, that I last saw h- alive on July 20, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Bodily Kinnod Disease

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Reynolds M. D.

7/24, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	7/24 1930

20. Undertaker C. Bucknum Address Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71238

PLACE OF DEATH
County of Ada
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

184

2. FULL NAME Anna Widdinger
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Nov 11- 1844
7. AGE: Years 85 | Months 8 | Days 4 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs Erna Threewitt
(Address) Emmett Idaho
15. Filed 7/16, 1930 J L Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 15, 1930
that I last saw her alive on July 14, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Strangulated femoral hernia (duration) yrs. mos. 4 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) R A Cummings M. D.
7/16, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 7/16 1930
20. Undertaker: C D Bruckman
Address Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, and NAMING should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71239

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas R. Faull

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75 -	3 -	5 -	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER James Faull.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Jim Faull
(Address) Emmett Idaho.

15. Filed 7-25, 1930 J. H. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January, 1930, to July 3rd, 1930
that I last saw him alive on July 14, 1930
and that death occurred, on the date stated above, at 9 m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
Chronic nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
7/25/ 1930 (Address) J. H. Reynolds Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	7/27 1930

20. Undertaker	Address
C. D. Buckmann	Emmett Idaho

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71240

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 2
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Grace Bryant
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Not known

7. AGE: 65 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS
10. NAME OF FATHER: George Talbot
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: R. W. Bryant
(Address) Wenatchee Wash.

15. Filed 7/2, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to July 1, 1930
that I last saw her alive on July 1, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
apoplexia two wks
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Arterio Sclerosis
several yrs (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? J. L. Reynolds
(Signed) M. D.
7/2, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho | Date of Burial: July 3 1930

20. Undertaker: C. D. Buckman | Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71241

AUG 14

PLACE OF DEATH
County of Gooding Co.
City of Wendell Ida.

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John R. Francis 90
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Feb. 22-1881

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
49	4	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER David Francis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Sarah Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Landau Eng

14. Informant (Address) Wm. J. Francis Wendell Ida.

15. Filed 7-18, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 17-July, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from none, 19 to , 19
that I last saw h alive on no time, 19
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Heart failure - natural causes

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) T. W. MacManus, M. D.
18-July, 1930 (Address) Buhl, Idaho

19. Place of Burial, Cremation, or Removal Ogden - Utah
Date of Burial 19

20. Undertaker L. J. Johnson
Address Buhl Ida

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED AUG 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71243

Local Registrar's No. 133

1. PLACE OF DEATH
County of Gooding
City of ( )
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph M Butler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): unknown
6. DATE OF BIRTH: unknown (Month) (Day) (Year)
7. AGE: about 35 to 40 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): unknown
10. NAME OF Father: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A C Thompson
(Address) Gooding
15. Filed 7/30 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 25 1930 to June 5 1930 that I last saw alive on June 5 1930, and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Rocky Mt Spotted Fever
(Duration) ... yrs. ... mos. 10 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J H Cromwell M. D.
7/1 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida. DATE OF BURIAL: 6-9- 1930
20. UNDERTAKER: A. E. Thompson ADDRESS: Gooding

MARGIN RESERVED FO

WRITE PLAINLY, WITH UNFADING INK—THIS
N. B.—Every item of information should be carefully supplied. AGE
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
very important. See instructions on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71243

PLACE OF DEATH
County of Gooding
City of Gooding

Registration District No. 24
Primary Registration District No.
(No. Gooding County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 134

2. FULL NAME Anna M Haas

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas Haas

6. DATE OF BIRTH (month, day and year): Jan 25 1896

7. AGE: Years 34, Months 5, Days 27. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hailey Ida

PARENTS
10. NAME OF FATHER: Denis Deasy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Boston
12. MAIDEN NAME OF MOTHER: Hurley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant (Address): Jas Haas

15. Filed 7-23, 1930 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 22, 1930
that I last saw her alive on July 22, 1930
and that death occurred, on the date stated above, at 1 00 m.
The CAUSE OF DEATH* was as follows:
Septicemia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary): Septic Sore Throat
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 22
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) T. E. Barker, M. D.
7/23, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone
Date of Burial: July 24 1930

20. Undertaker: C E Hickok
Address: Shoshone Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71244

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

9

2. FULL NAME Joan Kash Kash

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17-1930

7. AGE: Years | Months: 3 | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER: Sam Kash Kash
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER: Ella Laurence
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Idaho

14. Informant: Mrs Ella Kash Kash
(Address) Kooskia - Idaho

15. Filed July 28, 1930 J M Verbeekmans
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to July 28, 1930
that I last saw her alive on July 28, 19..
and that death occurred, on the date stated above, at 11 45 a.m.
The CAUSE OF DEATH* was as follows:
Whooping Cough.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
7/29, 1930 (Address) Kooskia

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71245

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 301

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME George W. Ford

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Leonora C Ford

6. DATE OF BIRTH (month, day and year) Oct-20

7. AGE 64 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Daniel Ford.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Eliza Ann Strait
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not-obtainable

14. Informant Leonora C. Ford.
(Address) Kooskia - Idaho

15. Filed July 22, 1930 J M Vaberkmans Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
No medical attendant: Died suddenly probably from Angina Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M Vaberkmans, M. D.
July 22, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Tahoe Cemetery | Date of Burial July 22 1930

20. Undertaker Geo. Trenary | Address Kooskia - Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71246

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 300

90

2. FULL NAME Paul Corbett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Corbett

6. DATE OF BIRTH (month, day and year)

7. AGE: 89 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not obtainable
12. MAIDEN NAME OF MOTHER: Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Susie Multhorn
(Address): Kooskia - Idaho

15. Filed July 10, 1930 J M Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Found dead in bath house. Had been a sufferer from chronic valvular heart disease for years
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M Verberkmoes, M. D.
July 10, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Indian Cemetery - Stites
Date of Burial: July 12 1930

20. Undertaker: Geo Tremary
Address: Kooskia

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71246

1 PLACE OF DEATH
County Idaho State Idaho Registered No.
Township ____ or Village States Vicinity or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Paul F. Corbett

(a) Residence. No. States, Idaho St., ____ Ward.
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	1/2 nez Perce Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia Corbett

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	82			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) States
(State or country) Idaho

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant James L. Maxwell
(Address) Lapwai, Idaho

15 Filed July 11, 1930 J. L. Maxwell
REGISTRAR

11—3164 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw him alive on July 10th, 1930,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Died Suddenly
____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	July 12, 1930
20 UNDERTAKER	ADDRESS
Geo N. Tunary	Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 96

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71247

PLACE OF DEATH

County of Jefferson

City of Rigby

Registration District No. 98

Primary Registration District No. 2176

Local Registrar's No. 205 (B)

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Max Briggs.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Babe

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Babe

6. DATE OF BIRTH (month, day and year): April 7, 1930

7. AGE: Years 0, Months 3, Days 8. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Babe

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10. NAME OF FATHER: Alvin Briggs.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Rigby, Idaho.

12. MAIDEN NAME OF MOTHER: Zenda Atkinson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rexburg, Idaho.

14. Informant: Alvin Briggs
(Address) Rigby, R. #1.

15. Filed 7/30, 1930 A. B. Eckersell Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 15, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15, 1930 that I last saw him alive on July 15, 1930 and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Found dead in bed
cause unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. R. Vert, M. D.

July 15, 1930 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 7/16/30 19

20. Undertaker: A. B. Eckersell Address: Rigby

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71248

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 7176
Anderson
Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME John Ulysses Pettingill.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
~~HUSBAND of~~ Armeda Pettingill.

6. DATE OF BIRTH (month, day and year) Oct. 8, 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	9	8	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Josiah Pettingill.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Ann Maria Wood.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs. J. U. Pettingill
(Address) Rigby, R. #1

15. Filed 7/30, 1930 A B Eckersell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 16, 1930
that I last saw h~~im~~ alive on July 15, 1930
and that death occurred, on the date stated above, at 11:30 A m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Lungs -
(duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Hospital Exam Pocatello & Idaho Falls
(Signed) Dr. A. Anderson M. D.
....., 19..... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	7/19/30 19

20. Undertaker A B Eckersell Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

PLACE OF DEATH

County of Jefferson

City of Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71249

Local Registrar's No. .....

98B

2. FULL NAME Robert Anglesey.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of ~~XXXXXXX~~ of Mary Anglesey.

6. DATE OF BIRTH (month, day and year) Dec. 23, 1848

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
81	6	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John Anglesey.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Catherine Preston.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant .....
(Address) .....

15. Filed 7/30, 1930. A B Eckersell Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to June 29, 1930 that I last saw him alive on ....., 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate

..... (duration) 8 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. R. West, M. D.

July 7, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Annis, Idaho.

Date of Burial: 7/2/30 19

20. Undertaker: A B Eckersell

Address: Rigby

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71250

PLACE OF DEATH
County of Jefferson
City of Rigby.

Registration District No. 98
Primary Registration District No. 7176

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Mike Sorenson.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (~~WIFE of~~) ~~XXXXXXX~~ Dora Sorenson.

6. DATE OF BIRTH (month, day and year) July 24 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	48	10	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Mr. Denniger.

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10. NAME OF FATHER John Sorenson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Mary Mickelson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Dora Sorensen
(Address) Lewisville, Idaho.

15. Filed 7/30, 1930. A B Eckersell Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ June 16 1930 to 19 that I ~~last saw him~~ He was dead when I arrived alive on 19 and that death occurred, on the date stated above, at 1.40 p m.

The CAUSE OF DEATH* was as follows:
Broken Neck
Fracture cervical Vertebrae
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Accident
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) A. J. Anderson, M. D.
June 19, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	6/19/30 19

20. Undertaker A B Eckersell — Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WHEN PRINTED, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71251

PLACE OF DEATH
County of Jefferson.
City of Ririe.
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.) 170
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Henry Ritchie.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 1888.

7. AGE	Years	Months	Days	If LESS than 1 day,
	42	1	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Logging.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Robert Ritchie.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Emma Johns.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Robert Ritchie
(Address) Ririe, Idaho.

15. Filed 7/30, 1930. A. B. Eckersell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Dead June 22, 1930
and that death occurred ~~on the date stated above~~, at about 8 m.
The CAUSE OF DEATH* was as follows:
Pistol Shot on head
self inflicted
Instant (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ira Taylor Cannon M. D.
6-23, 1930 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho.	June 27 1930

20. Undertaker A. B. Eckersell. Address Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71252

PLACE OF DEATH

County of Jefferson.

City of Rigby

Registration District No. 98

Primary Registration District No. 2176

West

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME Lorenzo Barnes Jenkins

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of ~~XXXX XXXXXX~~ Rosetta Jenkins.

6. DATE OF BIRTH (month, day and year) Nov 30 1870

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	7	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Utah.

PARENTS

10. NAME OF FATHER: William Jenkins.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Ellen Naylor.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Rosetta Jenkins
(Address) Rigby, Idaho. R. #1

15. Filed 7/30, 1930 A B Eckersell Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10, (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 9, 1930, that I last saw him alive on July 9, 1930 and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows: Empyema left lung.

(duration) yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? yes Paracentesis of chest

What test confirmed diagnosis? Paracentesis & Xray

(Signed) W. A. West, M. D.

July 15, 1930 (Address) Rigby, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewisville, Idaho.

Date of Burial: 7/14/30 19

20. Undertaker: A B Eckersell

Address: Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71253

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 17

(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James B Allen

(a) Residence. No. Grangeville St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Isabell Allen

6. DATE OF BIRTH (month, day and year) May 18 1846

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	1	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nashville Penn

PARENTS
10. NAME OF FATHER John Allen
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Louis Webber
(Address) Grangeville Idaho

15. Filed July 1, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to , 19
that I last saw h-- alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) L D Shipman M. D.
June 30, 1930 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	6-7-1930
20. Undertaker	Address
Hancock Mort Co	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; and OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71254

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 18

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

98A

2. FULL NAME James Stewart

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Stewart

6. DATE OF BIRTH (month, day and year) 4-22-1871

7. AGE	Years	Months	Days	If LESS than 1 day,
	39	3	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine

PARENTS
10. NAME OF FATHER Duncan Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Nannie Cameron
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs James Stewart
(Address) Libby Montana

15. Filed 8-1-30 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1930 to June 20, 1930
that I last saw him alive on June 20, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? not

What test confirmed diagnosis? Symptoms

(Signed) H Heber M. D.
June 21, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Libby Mont. | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 19 1930

71255

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71255

PLACE OF DEATH
County of Jerome
City of Hazelton

Registration District No. 23
Primary Registration District No. 2[illegible]17
(No. Wilson Lake)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

142

2. FULL NAME Tom Johnson
(a) Residence. No. Idaho Falls Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Johnson

6. DATE OF BIRTH (month, day and year) Nov. 5 1893

7. AGE Years 36 Months 8 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Oiler on
(b) General nature of industry, business, or establishment in which employed (or employer) machinery
(c) Name of employer Mystic Construction Co.

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Tom Johnson
(Address) Idaho Falls Ida

15. Filed July 30, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 7, 1930
that I last saw h— alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
accidental drowning
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) S Hopper, M. D.
7-8, 1930 (Address) Hazelton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls
Date of Burial: 7-9 1930

20. Undertaker: McHaim undt Co
Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

71256

DO NOT WRITE IN THIS SPACE

State File No. 71256

Local Registrar's No. 58

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

PLACE OF DEATH

County of Ada

City of Boise

(No. U.S.Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME HARLEM T. PALMER

(a) Residence. No. Montour, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Myrtle Palmer

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work steel worker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) Colo. (Boulder)
(State or country)

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) —
(State or Country)

14. Informant H. Cook
(Address) U. S. Veterans' Bureau, Boise, Ida.

15. Filed 7-21, 1930 W. H. Cloke Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to July 20, 1930
that I last saw him alive on July 20, 1930
and that death occurred, on the date stated above, at 6:07 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pul. chronic, active, far advanced C. - Pharyngitis, ulcerative T.B. Laryngitis, ulcerative T.B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinically

(Signed) F.C. SMITH, M. D.

July 21, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett, Idaho	7/22/30
20. Undertaker C. D. Bucknum	Address Emmett, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71257

DO NOT WRITE IN THIS SPACE
State File No. 71257

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 39

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Varcoe

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of married

6. DATE OF BIRTH (month, day and year) Apr 17, 1895

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~Edmonton, Canada~~ Fenelon Falls, Ontario

PARENTS

10. NAME OF FATHER David Varcoe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jennie Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Stanley J. Crull
(Address) R. 2 Box 218 Greenbluff Spokane Wash.

15. Filed July 20, 1930 Mrs. Helen M. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ... 19 ... to ... 19 ...
~~that I last saw h~~ alive on ... 19 ...
and that death occurred, on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was as follows:
From Gun Shot Wounds -
Homicide
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? ...

(Signed) Robt. J. Durrell Justice of the Peace-acting Coroner M. D.
July 18, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Daisy Wash.	7/21/30 19
20. Undertaker M. C. Chamberlin	Address Kellogg Ida.

RECEIVED NOV 5 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM, OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

71257

Robert L. Duvall
Kellogg, Idaho

Dear ~~Doctor~~ Sir:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:
George Varcoe who was killed at Kellogg, Idaho on July 18, 1930
Cause of death given as "From Gunshot Wounds."

Information DESIRED in order to complete certificate:

WAS THIS SUICIDE, HOMICIDE, OR ACCIDENT.

PLEASE ANSWER BELOW:

George Varcoe was shot to death by Ellis Nining - the papers state 5 bullet holes in Varcoe's body - but there were 7 -
Am attaching a copy of the Kellogg Evening News which gives an account of the affair

Robt. L. Duvall
Justice of the Peace
-acting as Coroner-

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

7125-8

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71258

PLACE OF DEATH

County of Idaho

City of Riggins

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

183

2. FULL NAME James Mason Kerr

(a) Residence. No. Riggins, Idaho St. ~~Born Sewickley, Penn.~~

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 14, 1889

7. AGE: 41 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Livestock

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Sewickley, Pa.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: P. B. Carter

(Address) Boise Idaho

15. Filed Aug. 1, 1930 Bessie N Lepper State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1930, to May 4, 1930 that I last saw him alive on May 4, 1930 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Gun Shot. Head, entered Parietal, right side, came out roof mouth.

(duration) yrs. 7 hours ds.

CONTRIBUTORY (Secondary): homicide

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms, History

(Signed) J. P. Weber, M. D.

May 7, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pittsburg Pa

Date of Burial: shipped 5-7-30 19

20. Undertaker: J. H. Adair

Address: Weiser, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1930

71259

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71259

PLACE OF DEATH

County of BINGHAM

City of BALCKFOOT

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 117

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

38

2. FULL NAME MURNEY P JARVIS

(a) Residence. No. ..... St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male ~~White~~

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 13th, 1883

7. AGE Years 47 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Telegraph operator

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Picton Ontario

PARENTS

10. NAME OF FATHER Samuel Jarvis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Feletta Blair

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Harold Goldsworthy
(Address) Blackfoot

15. Filed July 24, 1930 Mrs Helen E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24th, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20th, 1928, 19 , to July 24th 1930 that I last saw him alive on July 24th 1930, 19 and that death occurred, on the date stated above, at 5:25 A m.

The CAUSE OF DEATH* was as follows:

Syphilis

Don't know (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

— (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Wassermann

(Signed) G. H. Williams, M. D.

July 24th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Boise Idaho — Date of Burial 19

20. Undertaker E. J. Peck — Address Blackfoot

RECEIVED AUG 11 1930

71260

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71260

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 101

PLACE OF DEATH
County of Kootenai
City of Rose Lake
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Edwin Humphrey

(a) Residence. No. St. Kellogg, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1905

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bunker Hill & Sullivan

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER James Humphrey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Mary Utt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant G. M. Stapish
(Address) Chewelah, Wn.

15. Filed 7-16-, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows: accidental drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [illegible] M. D.
July 3, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Chewelah Wn	July 3 1930
20. Undertaker	Address
Thornhill & Co	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71261

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71261

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 61
(No. U.S.Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME EDMUND A. MUNOZ

(a) Residence. No. 1613 No. 20th St., St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of I. Lawrie Munoz

6. DATE OF BIRTH (month, day and year) Mar. 21, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	4	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work physician
(b) General nature of industry, business, or establishment in which employed (or employer) xx
(c) Name of employer xx

9. BIRTHPLACE (city or town) La.
(State or country) USA

PARENTS
10. NAME OF FATHER xx
11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)
12. MAIDEN NAME OF MOTHER xx
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant H. Bock
(Address) U. S. Veterans' Bureau, Boise, Ida

15. Filed 7-26, 1930 W. N. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6, 1930, to July 24, 1930
that I last saw him alive on July 24, 1930
and that death occurred, on the date stated above, at 4:30 p.m.
The CAUSE OF DEATH* was as follows:
Tbc. pulmonary, chronic, active, far advanced C.

(duration) yrs. mos. ds.
CONTRIBUTORY xx
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? xx
Did an operation precede death? no Date of xx
Was there an autopsy? yes
What test confirmed diagnosis? post mortem and lab.
(Signed) F. C. SMITH, M. D.
July 25, 1930 (Address) Reg. Med. Officer U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/26/30 19
20. Undertaker Wm. McGratney.	Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71262

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 206
(No. Idaho Soldiers Home Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

135

2. FULL NAME Michael Archer.
(a) Residence. No. Idaho Soldiers Home. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 35 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widower.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1842.
7. AGE: 88 Years | Months: 0 | Days: 0 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of the Civil War.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Monroe County, Ohio.

PARENTS
10. NAME OF FATHER Unknown.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant (Address) L. C. Lick. 413. S. 12 Street. Boise, Idaho.
15. Filed 7-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to July 19, 1930
that I last saw him alive on July 17, 1930
and that death occurred, on the date stated above, at ..... m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Secondary Anemia from Prostatic Hemorrhage
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Carcinoma Prostate
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) Fred A. Kellogg M. D.
7/20, 1930 (Address)

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: July. 21 1930
20. Undertaker: Summers & Krebs. Address: Boise, Ida.

Almond.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71263

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 207
(No. 918 N. 16th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

37B

2. FULL NAME Mrs. Frances Levand Buhler.

(a) Residence. No. 918 N. 16th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William A. Buhler.

6. DATE OF BIRTH (month, day and year) February 10th 1901

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	5	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Belt, Montana.

PARENTS

10. NAME OF FATHER Frank ~~Buhler~~ Levand.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Agnes----------
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant Wm. A. Buhler.
(Address) Boise, Idaho.

15. Filed 7-24, 1930 W. H. Rhoden Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 21st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to July 21, 1930
that I last saw her alive on July 21, 1930
and that death occurred, on the date stated above, at 6:05 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis.

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Utah
Did an operation precede death? no Date of
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) F. O. Almond, M. D.
7/22/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/23/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71264

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 208

71B

2. FULL NAME Narciso Bilbao
(a) Residence. No. 807 Grove St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Teodora Barayasarra

6. DATE OF BIRTH (month, day and year) May 31-1901

7. AGE Years 29 Months 1 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rigoitia
(State or country) Spain

PARENTS

10. NAME OF FATHER Martin Bilbao
11. BIRTHPLACE OF FATHER (city or town) Rigoitia
(State or Country) Spain
12. MAIDEN NAME OF MOTHER Teresa Talleria
13. BIRTHPLACE OF MOTHER (city or town) Rigoitia
(State or County) Spain

14. Informant (Address) Mateo Arregui

15. Filed 7-25, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/20, 1930, to 7/21, 1930
that I last saw him alive on 7/21 1930
and that death occurred, on the date stated above, at 8 PM

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebro spinal meningitis (Type not proved)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? NS Date of
Was there an autopsy? NS
What test confirmed diagnosis? [illegible]
(Signed) Ralph Hall, M. D.
7/24, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal St Johns Cemetry
Date of Burial 7-24 1930

20. Undertaker Schreiber & McClain
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71265

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 209
(No. 1718 N. 19th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Minnie Baker Bean 90
(a) Residence. No. 1718 N. 19th st. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Leo A. Bean.
6. DATE OF BIRTH (month, day and year): March 22nd 1868
7. AGE: 62 Years; Months: 4; Days: 3; If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Nephi, Utah.

PARENTS
10. NAME OF FATHER: W. G. Baker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): London, England.
12. MAIDEN NAME OF MOTHER: Marie Bertelsen.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Denmark.

14. Informant (Address): Mrs. Geneva Russell. Nampa, Idaho.
15. Filed 7-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 25th 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May, 1930, to July 25, 1930
that I last saw her alive on July 25, 1930
and that death occurred, on the date stated above, at 7 P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Manuel Stenosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemiplegia
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Yes
(Signed) Chas V Gennery, M. D.
7/26/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Richfield, Utah. Date of Burial: Shipped 7/28/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71266

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 210
(No. 1520 N. 11th street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. **FULL NAME** Mrs. Annie D. Strader
(a) Residence. No. 1302 N. 21st St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W. B. Strader.

6. DATE OF BIRTH (month, day and year): November 14th 1857

7. AGE: 72 Years | Months: 8 | Days: 17 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ky.

PARENTS

10. NAME OF FATHER: Wm. Livingston.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know.
12. MAIDEN NAME OF MOTHER: Catherine A. Steele.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ind.

14. Informant (Address): W. B. Strader. Boise, Idaho.

15. Filed 7-31, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 31st 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930 to July 31, 1930 that I last saw her alive on July 28, 1930 and that death occurred, on the date stated above, at 2:50 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary) Hypertension & arteriosclerosis (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) T. N. Braxton, M. D.
7/31/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8/2/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71267

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 299
(No. _____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Cooper 90

(a) Residence. No. 1816 North 13th St.
(Usual place of abode.)
Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Black	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Cooper

6. DATE OF BIRTH (month, day and year) 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	59			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Cleaning
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Toronto Canada

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Katherine Malone
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Canada

14. Informant (Address) Mrs. Julia Cooper Boise

15. Filed 7-31, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 29, 1930, that I last saw her alive on July 29, 1930, and that death occurred, on the date stated above, at 2 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute mania

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 9
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. H. Parker, M. D.
July 30, 1930 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 7/30 1930

20. Undertaker: Schrader & McCaud — Address: Boise

Parker.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71268

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 212

1004

2. **FULL NAME** Chrisula J. Boris

(a) Residence. No. Sweet St. Ada
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	—

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 30 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	4	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweet Ada

PARENTS

10. NAME OF FATHER James Boris

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece

12. MAIDEN NAME OF MOTHER Violet Chingas

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Greece

14. Informant (Address) George J Karras Boise

15. Filed 7-31, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 29, 1930
that I last saw her alive on July 29, 1930
and that death occurred, on the date stated above, at 9.55 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Pertussis
approximate (duration) — yrs. — mos. 25 ds.

18. Where was disease contracted if not at place of death? Sweet Idaho.
Did an operation precede death? No Date of
Was there an autopsy? No. (Refused.)
What test confirmed diagnosis? X-ray-throat culture

(Signed) Harmon A. Brennan M. D.
July 30, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 7-30 1930

20. Undertaker: Schreiber McCann — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71269

PLACE OF DEATH

County of Ada.
City of Boise.

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 53
(No. Ridenbaugh Canal south of U.P.Depot.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Allen Theodore Brashears.
(a) Residence. No. 1302½ N. 8th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

182

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Brashears.

6. DATE OF BIRTH (month, day and year) May 26th 1907

7. AGE Years 23 Months 1 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Pleasant Thomas Brashears.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kan.
12. MAIDEN NAME OF MOTHER Daisy Huckba.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Caldwell, Ida.

14. Informant (Address) Mrs. Ralph McGrath. Eagle, Idaho.

15. Filed 7-7, 30 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2nd 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ 19 to 19 ~~that I last saw h alive on~~ 19 ~~and that~~ death occurred, on the date stated above, at about 8 30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental Drowning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No. —
What test confirmed diagnosis? —
(Signed) W McBratney Coroner, ~~M. D.~~
, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Dry Creek Cemetery
Date of Burial 7-6-30 19

20. Undertaker Wm. McBratney.
Address Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71270

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 54
(No. 4 miles Southwest of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Peter S. Dick.
(a) Residence. No. 4 Miles Southwest of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Roseanna Dick

6. DATE OF BIRTH (month, day and year) March 11th 1854

7. AGE Years	Months	Days	If LESS than 1 day, ---------- hrs. or min.
76	3	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fayette Co. Pa.

PARENTS

10. NAME OF FATHER John Dick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER -----Shultz.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pa.

14. Informant (Address) J. S. Dick. Boise, Idaho.

15. Filed 7-7, 1930 A H Wheeler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 26th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 25, 1930 that I last saw him alive on June 25, 1930 and that death occurred, on the date stated above, at 3:25 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A B Borck, M. D.
6/27/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: 6/30/30 19
20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71271

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 55
(No. Eagle, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Baker.

(a) Residence. No. Eagle, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

170

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Baker.

6. DATE OF BIRTH (month, day and year) April 6th 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kent, England.

PARENTS

10. NAME OF FATHER Wm. Baker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant Mrs. Annie Baker.
(Address) Eagle, Idaho.

15. Filed 7-14 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~- - - -

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7127

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 56
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Joe William Cartwright.

(a) Residence. No. 6 miles west of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July. 4. 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Oscar Cartwright.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana.
12. MAIDEN NAME OF MOTHER Eva Lumpkin.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant (Address) Oscar Cartwright. Boise, Idaho. R.D. # 1.

15. Filed 7-15, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 14, 1930, that I last saw him alive on July 14, 1930, and that death occurred, on the date stated above, at 11 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Congenital defect about Common duct causing stenosis & marked icterus (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. B. Bond, M. D.
July 14, 1930 (Address)

19. Place of Burial, Cremation, or Removal	Date of Burial
Joplin Cemetery.	July. 14. 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71273

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 59
(No. Mountain Home Highway, South of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Sue Peterman Palmer.

(a) Residence. No. Garden & Fairview Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of W. H. Palmer.

6. DATE OF BIRTH (month, day and year) May 31st 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	1	18	0

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colfax, Wash.

PARENTS

10. NAME OF FATHER Allen B. Peterman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Elizabeth Jenkins.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Paris, Ill.

14. Informant Mrs. A. B. Peterman.
(Address) Boise, Idaho. Route #2.

15. Filed 7-22 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ; 19 ; to ; 19
~~that I last saw him alive on~~ about 19
~~and that~~ death occurred, on the date stated above, at 12.15 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto Accident, Skull Fractured, Death occured about 30 minutes after accident. (duration) 1 yrs. mos. ds.
accident was accidental.
CONTRIBUTORY (Secondary)
No Inquest held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Wm. McBratney, Coroner, M. D.
7-22-, 19 30 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/22/30 19
20. Undertaker: Wm. McBratney.	Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71274

Local Registrar's No. 60

170

2. FULL NAME William James Bane

(a) Residence. No. 1/2 Mile north of Star, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16 – 1891

7. AGE: 38 Years | Months: 11 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Emmett Idaho

PARENTS

10. NAME OF FATHER: Price Bane

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Nellie Miller

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Boise G Riggs Sr.
(Address) Emmett Idaho

15. Filed 7-22, 1930. W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July – 22 – 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from ..... 19.. to ..... 19.. that I last saw h... alive on ..... 19.. and that~~ death occurred, on the date stated above, at about 11.45 a. m.

The CAUSE OF DEATH* was as follows: Suicide. Shot himself in head with 22 Caliber rifle.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): No Inquest held.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) W McBrahey Coroner M.D.

7/23, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Emmett Idaho | Date of Burial: July 24 1930

20. Undertaker: C D Buckman | Address: Emmett Idaho

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED AUG 9 1930

DO NOT WRITE IN THIS SPACE

State File No. 71275

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Eagle

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 62

(No. Eagle, Idaho R.#1)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cecil Leroy McPherson. 182

(a) Residence. No. Eagle, Idaho R.#1 St.

(Usual place of abode.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 23rd 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	3	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eagle, Idaho.

PARENTS

10. NAME OF FATHER John McPherson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boone Co. Iowa.

12. MAIDEN NAME OF MOTHER Ada. Freudenthaler.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Eagle, Idaho.

14. Informant John McPherson.
(Address) Eagle, Idaho

15. Filed 7-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July-25th-1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ----------, 19--, to ----------, 19--
that I last saw h-- alive on About ----------, 19--
and that death occurred, on the date stated above, at 9:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental Drowning.

Child was in water about 20 Minutes. (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) No Inquest.
(duration) ..yrs. ..mos. ..ds.

18. Where was disease contracted if not at place of death? ----------
Did an operation precede death? No. Date of ----------
Was there an autopsy? No.
What test confirmed diagnosis? ----------

(Signed) Wm. McBratney M.D.
7/26/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Star Cemetery. Date of Burial: 7/27/30, 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71276

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boise

City of

Registration District No.

Primary Registration District No. Local Registrar's No.

(No. 10 Miles North of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Carol Wana Bumgardner.

(a) Residence. No. State and Vine Streets. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 25.1920.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
9	7	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Ralph. S. Bumgardner.

11. BIRTHPLACE OF FATHER (city or town) Deerlodge Mont.
(State or Country)

12. MAIDEN NAME OF MOTHER Alice. M. Smith.

13. BIRTHPLACE OF MOTHER (city or town) Ill.
(State or County)

14. Informant Ralph. S. Bumgardner.
(Address) R.D. # 1. Boise, Idaho.

15. Filed 7-28, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 27, 1930, that I last saw h. alive on July 27, 1930, and that death occurred, on the date stated above, at 4:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto accident - fractured Rib punctured lung + probably abdominal injury
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Body + Hundmon
(Signed) R. S. Bumgardner, M. D.
July 28, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	July. 30 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71277

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 191

(No. 304 South 17th street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. **FULL NAME** Glenn Elmo Heddon

(a) Residence. No. 304 South 17th St.

(Usual place of abode.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) September 9th 1924

7. AGE Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
5	9	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ----------
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lima, Idaho.

PARENTS

10. NAME OF FATHER George Heddon.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER Margaret Stang.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant Elizabeth Heddon.
(Address) Boise, Idaho.

15. Filed 7-1, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20th, 1930, to June 29th, 1930, that I last saw him alive on June 28th, 1930, and that death occurred, on the date stated above, at 12:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Double Broncho Pneumonia and Oedema -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles -

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Brock M. D.

6/30/30, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 6/30/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71278

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 192
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Gebhard Marxer
(a) Residence. No. 1164 River St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 17 yrs. mos. ds. How long in U. S. if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Marxer

6. DATE OF BIRTH (month, day and year) Jan. 31-1877

7. AGE Years 53 Months 4 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ochsenhausen Wuertenberg Germany

PARENTS
10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Julius Justice 1408 Elgin Ave Forest Park

15. Filed 7-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1930, to June 29, 1930
that I last saw him alive on June 28, 1930
and that death occurred, on the date stated above, at 10.30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Nov-1929
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French, M. D.
July 1, 1930 (Address) ~~Jude~~ Boise Ida.

19. Place of Burial, Cremation, or Removal St. Johns Cemetery
Date of Burial 7/2 1930

20. Undertaker Schreiber & McCann
Address Boise, Ia.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71279

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 193

(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

98 B

2. FULL NAME Harry Mitchell.

(a) Residence. No. Jerome, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 21 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nellie Mitchell.

6. DATE OF BIRTH (month, day and year) June 6th 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer and Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Eugene, Oregon.

PARENTS

10. NAME OF FATHER M. W. Mitchell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lafayette, Ind.
12. MAIDEN NAME OF MOTHER Antonette Curry.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lafayette, Ind.

14. Informant Dr. F. W. Mitchell.
(Address) Blackfoot, Idaho.

15. Filed 7-7, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to July 6, 1930
that I last saw him alive on July 6, 1930
and that death occurred, on the date stated above, at 7:10 P. M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocardetes
Arteriosclerosis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings

(Signed) W. H. Rhodes, M. D.
7/6/30, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Weiser, Idaho. Date of Burial: Shipped 7/7/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71280

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 194

(No. 49)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Alice Teresa Corbett (Sister M Eugene)

(a) Residence. No. St. Alphonsus Hospital St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 22, 1874

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56		13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago, Ill.

PARENTS

10. NAME OF FATHER Thomas Corbett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Ellen Conroy

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Sister M Cenacle (Sister) Boise Ida

15. Filed 7-8, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1930, to July 5, 1930, that I last saw her alive on July 5, 1930, and that death occurred, on the date stated above, at 6 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Breast

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Yes

(Signed) Chas. V. Gennaro, M. D

July 7, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: St Johns Cemetery — Date of Burial: 7-7-1930

20. Undertaker: Schreiber McCann — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71281

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 195
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Frank Wolverton Manville.
(a) Residence. No. 1124. Fort St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Manville.

6. DATE OF BIRTH (month, day and year) Feb. 12.1874.

7. AGE Years 56. Months 4 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Central City.
(State or country) Colorado.

PARENTS
10. NAME OF FATHER John. S.D. Manville.
11. BIRTHPLACE OF FATHER (city or town) Penn.
(State or Country)
12. MAIDEN NAME OF MOTHER Anna. R. Wolverton.
13. BIRTHPLACE OF MOTHER (city or town) Penn.
(State or County)

14. Informant Mrs. F.W. Manville.
(Address) 1124. Fort Street, Boise, Idaho.

15. Filed 7-8, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 15, 1930, to Death, 19..
that I last saw him alive on July 7, 1930
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical + lab. findings
(Signed) L. F. West, M. D.
7-8, 1930 (Address) 413 Eachman Bldg.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: July.9.30.
20. Undertaker: Summers & Krebs. Address: Boise, Ida.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71282

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 196
(No.) Windsor Hotel--7th and Idaho St.
(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. **FULL NAME** Charles Henry Wilks.

(a) Residence. No. Windsor Hotel. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs, or ....min.
About 50			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. **BIRTHPLACE** (city or town) Unknown.
(State or country)

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) "
(State or County)

14. Informant Pearl Allen.
(Address) Boise, Idaho

15. Filed 7-9, 1930 W. R. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 3rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 2, 1930
that I last saw him alive on July 2, 1930
and that death occurred on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Spinal cord pressure on cervical region suspected to be a tumor growth

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W R Frazer, M. D.
7/3/30, 1930 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 7/9/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71283

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 197
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Johnny Bertsias

(a) Residence. No. 435 South 11th street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	Greek.	Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) February 16th 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	4	21	---

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Everett, Washington.

PARENTS

10. NAME OF FATHER Y. N. Bertsias.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece
12. MAIDEN NAME OF MOTHER Mary ---
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Greece.

14. Informant Y. N. Bertsias.
(Address) Boise, Idaho.

15. Filed 9-14 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from --- 19--- to --- 19---
that I last saw him alive on --- 19---
and that death occurred, on the date stated above, at 6 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Auto accident. Jury verdict "Unavoidable accident and the driver occupant of the car exonerated." Inquest held 7/8/30.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No. Date of ---
Was there an autopsy? No.
What test confirmed diagnosis? ---

(Signed) W. McBratney, Coroner
7/8/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/10/30 19
20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71284

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. Boise Airport.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 198

188 D

2. FULL NAME Albert L. Musgrove.
(a) Residence. No. 1326 Vermont St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 11th 1914.

7. AGE Years 16 Months 2 Days 23 If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Airplane service at
(b) General nature of industry, business, or establishment in which employed (or employer) Boise Airport.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Calvin Musgrove.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.
12. MAIDEN NAME OF MOTHER Jennie Noel.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas.

14. Informant (Address) Calvin Musgrove. Boise, Idaho.

15. Filed 7-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ----------, 19--, to ----------, 19--
that I last saw h..... alive on ----------, 19--
~~and that~~ death occurred, on the date stated above, at about 10:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidently killed in airplane crash. Plane fell about 350 feet, catching fire immediately on hitting the ground. Body was badly burned.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No inquest was held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? ---- Date of ----
Was there an autopsy? ---- No. ----
What test confirmed diagnosis? ----
(Signed) W. McGratney Coroner, ~~M. D.~~
7/12/30, 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 7/5/30 19

20. Undertaker Summers & Krebs. Address Boise, Idaho.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71285

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 199
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Mrs. Alice May Coffin.

(a) Residence. No. 1503. N. 17 Street. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August. 22. 1876.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53.	10	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake Utah.

PARENTS

10. NAME OF FATHER Joseph. N. Hicks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Helena Hartwell.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Evenston Iowa.

14. Informant Miss. Ruth Johnston.
(Address) 1503. N. 17. Street, Boise, Idaho.

15. Filed 7-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~
, 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
Did not attend deceased
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage from stomach
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of at Salt Lake City Hosp
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) Edmund Bruce, M. D.
July 12, 1930 (Address) Boise,

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery,	July. 12. 30.
20. Undertaker	Address
Summers & Krebs.	Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71286

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise. Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 200

(No. St. Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

11B

2. **FULL NAME** Mrs. Cora May Mosier.

(a) Residence. No. Eagle, Idaho. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of E. O. Mosier.

6. DATE OF BIRTH (month, day and year) September 5th 1870

7. AGE Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
59	10 ~~68~~	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nebraska. (State or country)

PARENTS

10. NAME OF FATHER Harvey Jillson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.

12. MAIDEN NAME OF MOTHER Elizabeth--------

13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York.

14. Informant E. O. Mosier. (Address) Eagle, Idaho.

15. Filed 7-14 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6th 1930, to July 12th 1930, that I last saw her alive on July 11th 1930, and that death occurred, on the date stated above, at 7:15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Uraemic poisoning following Appendicitis.

Influenza + Appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Uremia. ? Shock,

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Eagle Ida

Did an operation precede death? No Date of July 8th

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. R. Kennedy, M. D.

7/14/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/14/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7287

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 201

(No. St. Alphonsus Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. **FULL NAME** Frank Lacy McFall

(a) Residence. No. Eagle, Idaho. R#1. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) [illegible] 1921

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
8	10	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In school.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Eagle, Canada.
(State or country)

PARENTS

10. NAME OF FATHER Frank C. McFall.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Belle P. Davis.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Colorado.

14. Informant Mrs. F. C. McFall.
(Address) Eagle, Idaho.

15. Filed 7-14, 1930 W. H. Rhoades Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 12, 1930
that I last saw h[illegible] alive on July 12, 1930
and that death occurred, on the date stated above, at 4:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

2 bar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eu Collins M. D.

7/14/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasant[illegible], Idaho.	7/15 1930

20. Undertaker Jm. McBratney Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71288

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 202
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Evelyn Edith Kibby.

(a) Residence. No. Cascade, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) August 29th 1918

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
11	10	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In school.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Olex, Oregon.

PARENTS

10. NAME OF FATHER Grover Kibby.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hoskson, Oregon.
12. MAIDEN NAME OF MOTHER Eva Smith.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) Grover Kibby. Cascade, Idaho.

15. Filed 7-14, 1930 W. D. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1930 to July 13 1930 that I last saw h.er alive on July 13. 1930 and that death occurred, on the date stated above, at 7:25 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rocky-Mountain Spotted fever
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Tick Bite
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Cascade, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis Staphylococcus Faecalis
(Signed) Ethel V. Porter M. D.
7/14/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cascade, Idaho.	7-15-30 19
20. Undertaker	**Address**
Wm. McBratney.	Boise, Idaho.

Stewart.

RECEIVED AUG 9 1930

IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7128

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 203
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Mrs. Eva Pickering Shawhan.

(a) Residence. No. Payette, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of B. P. Shawhan

6. DATE OF BIRTH (month, day and year) February 12th 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	5	5	------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Knightstown, Ind.

PARENTS

10. NAME OF FATHER U. Pickering.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Elizabeth Englerth.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant B. P. Shawhan.
(Address) Payette, Idaho.

15. Filed 7-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-6, 1930, to 7-17, 1930
that I last saw h[illegible] alive on 7-17, 1930
and that death occurred, on the date stated above, at 1:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia.

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Generalized Carcinomatosis
(Primary R. breast) (duration) 12 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Physical & X-ray findings

(Signed) L. T. West, M. D.
7/18/30, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/19/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71290

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 204
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Margurite Grace Wonacott.
(a) Residence. No. 1719. N. 26 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sylvester. A. Wonacott.

6. DATE OF BIRTH (month, day and year) May. 17.1903.

7. AGE Years 27 Months 2 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Iowa.
(State or country)

PARENTS
10. NAME OF FATHER Charles Carter.
11. BIRTHPLACE OF FATHER (city or town) Iowa.
(State or Country)
12. MAIDEN NAME OF MOTHER Grace Moss.
13. BIRTHPLACE OF MOTHER (city or town) Iowa.
(State or County)

14. Informant (Address) Sylvester. A. Wonacott. 1719. N. 26. St. Boise, Idaho.

15. Filed ..... 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th, 1930, to July 21, 1930
that I last saw her alive on July 21st, 1930
and that death occurred, on the date stated above, at 0:35 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Septicemia & General Peritonitis
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Abortion with infection (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 21-30
Was there an autopsy? no
What test confirmed diagnosis? pus found in pelvis
(Signed) C. M. Taylor, M. D.
July 23rd 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial July. 23. 30.
20. Undertaker Summers & Krebs. Address Boise, Ida.

RECEIVED AUG 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71292

PLACE OF DEATH

County of Ada

City of Meridian

Registration District No.

Primary Registration District No.

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Andrew William Snyder

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Ida May Snyder

6. DATE OF BIRTH (month, day and year) Jan 30 1837

7. AGE	Years	Months	Days	If LESS than 1 day, ~~hrs. or~~ min.
	93	3	19	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Dont Know
(State or country) New York

PARENTS

10. NAME OF FATHER Wm Snyder

11. BIRTHPLACE OF FATHER (city or town) Dont Know
(State or Country)

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or Country)

14. Informant Ida May Snyder
(Address) Meridian Ida

15. Filed May 20, 1930 N F Neal
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1930, to 19, 1930
that I last saw ~~she~~ alive on May 18, 1930
and that death occurred, on the date stated above, at 5:30 m.
The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Flu.

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N F Neal, M. D.

5-21, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or Removal	Date of Burial
Meridian Ida	5/21/1930
20. Undertaker B. W. Robison	Address Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44

Primary Registration District No. .....

(No. ....., ... St.)

File No. 71294

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Coleman Barbour

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 5 (Day) 1859 (Year)

7. AGE: 71 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Edward Barbour

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary Knickpetue

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C R Barbour

(Address) .....

15. Filed Aug 6 1930

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18th 1930, to June 25th 1930, that I last saw him alive on June 25th 1930, and that death occured on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Tic (Spotted) fever

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Benjamin M. D.

July 1930 (Address) Council, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: June 27 1930

20. UNDERTAKER: J. A. Henderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-18

RECEIVED AUG 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17

Primary Registration District No.

(No. .... St.)

File No. 71295

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Armocost

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 27 (Day) 1930 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Cambridge

10. NAME OF FATHER Earl Armocost

11. BIRTHPLACE OF FATHER (State or Country) Cambridge

12. MAIDEN NAME OF MOTHER Bernice Haviland

13. BIRTHPLACE OF MOTHER (State or Country) Cambridge

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Armocost

(Address) .....

15. Filed Aug 5 1930

US. R. I. WHITEMAN
CAMBRIDGE, IDAHO

Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 27 (Day) 1930 (Year) 161a

17. I HEREBY CERTIFY, That I attended deceased from July 27 1930, to July 27 1930, that I last saw h... alive on July 27 1930, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Birth caused by Acute Nephritis in Mother

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt M.D.

..... 19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: 7/28 1930

20. UNDERTAKER: J. A. Fiddler — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Mesa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 88

Primary Registration District No.

(No. ....., ... St.)

File No. 71296

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marry Matilda Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widdow (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1856 (Year)

7. AGE 74 .....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Arkansaw

10. NAME OF FATHER Willie Baker

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X Stanley Woods

(Address)

15. Filed Aug 12 1930

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO

Local Registrar

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH July 2 1930 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No M.D. called 191....., to ..... 191....., that I last saw h.....alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio-sclerosis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. T. Whiteman M. D.

.....19..... (Address) Cambridge, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Valley

DATE OF BURIAL: July 2 1930

20. UNDERTAKER: Jeffer Dilson

ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24654

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71297

PLACE OF DEATH

County of Washington

City of Cambridge

Registration District No. 4

Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

159

2. FULL NAME Infant Rippen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cambridge, Idaho.

PARENTS

10. NAME OF FATHER Herman Rippen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Nora Kester

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hamilton Kansas

14. Informant Herman Rippen

(Address) Cambridge, Ida.

15. Filed 8/4/30, 19.... DR. R. T. WHITEMAN CAMBRIDGE, IDAHO Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 4 (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1, 19 30, to Aug. 4, 1930, 19
that I last saw him alive on Aug. 1, 1930, 19
and that death occurred, on the date stated above, at 10:00 A m.
The CAUSE OF DEATH* was as follows:

Congenital Atalectasis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uterine inertia.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) R. T. Whiteman, M. D.
8-4-30, 19 (Address) Cambridge Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cambridge, Ida.	8-4-30

20. Undertaker	Address
J. A. Hudelson	Cambridge, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71298

PLACE OF DEATH
County of Adams
City of Mesa

Registration District No. 77
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Mrs Armelda Houston

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. ~~Single, Married,~~ Widowed, or ~~Divorced (write the word.)~~ Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Houston

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77	1852	Sept	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Willamette Valley, Oregon

PARENTS
10. NAME OF FATHER John Kenzer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Armelda Kenzer
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Thomas Houston

15. Filed 8-5-30, 19.....
DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to July 20, 1930
that I last saw her alive on July 20, 1930
and that death occurred, on the date stated above, at 12 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy. First stroke about 11 years ago.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Debility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) T. A. Benjamin, M. D.
July 21, 1930 (Address) Council, Idaho

19. Place of Burial, Cremation, or Removal: Cotton Wood Cemetry
Date of Burial: 7/21 1930

20. Undertaker: J A Hudelson
Address: Cambridge

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Lava Hot Springs (No. ..... St.)

Registration District No. 84

Primary Registration District No. 2161

File No. 71299

Registered No. 187

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dee Scott Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Lava Hot Springs Ida

10. NAME OF FATHER: William Earl Hill

11. BIRTHPLACE OF FATHER (State or Country): Wellsville Utah

12. MAIDEN NAME OF MOTHER: Nada Lone Egan

13. BIRTHPLACE OF MOTHER (State or Country): Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W E Hill By C A Rich

(Address) Lava H.S. (copy from Birth certificate)

15. Filed Aug - 3 1930

Mrs. I. I. Fitz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

101 B

16. DATE OF DEATH: July (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1930, to Aug 2 1930, that I last saw him alive on Aug 2 1930, and that death occurred on the date stated above, at 10 20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Rich M. D.

8-2-1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 13 1930

Current Complete

May 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71300

PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Primary Registration District No. 2161 Local Registrar's No. 5861

(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

114a

2. FULL NAME Jessie Richardson

(a) Residence. No. 141 Garfield. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind? 3/8	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William Richardson

6. DATE OF BIRTH (month, day and year) June 23, 1886

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	II	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Anaconda, Mont.

PARENTS

10. NAME OF FATHER James Landry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Rosa Lavatta

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Montana

14. Informant (Address) Wm. Richardson, Pocatello, Idaho

15. Filed July 25, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 20, 1930 (Month) (Day) (Year)

Treated by Dr. Newton, Pocatello

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Strangulated Hernia

2 Days (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gangrene intestines

2 Days (duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis? Operation

(Signed) Tony N. Thuler M. D.
....., 19..... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal: Mountain View Cem. Pocatello, Idaho — Date of Burial: 5/31/30/ 19

20. Undertaker: Hall Mortuary, Pocatello, Ida — Address

N. B.—Every item of information should be carefully supplied. And should be clearly written. Ink should be used. Every item should be properly classified. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 13 1930

Current Complete

May 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. .....

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello Primary Registration District No. 2161 Local Registrar's No. 5861

(No. General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Duplicate

2. FULL NAME Jessie Richardson

(a) Residence. No. 141 Garfield. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 3/8	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William Richardson

6. DATE OF BIRTH (month, day and year) June 23, 1886

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	II	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Anaconda, Mont.

PARENTS

10. NAME OF FATHER James Landry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Rosa Lavatta

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Montana

14. Informant (Address) Wm. Richardson, Pocatello, Idaho

15. Filed July 25, 30, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29, 1930 (Month) (Day) (Year)

Treated by Dr. Newton, Pocatello

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at 10. A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Strangulated Hernia

2 Days (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Gangrene intestines

2 Days (duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Henry R. Wheeler M. D.

....., 19.... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem. Pocatello, Idaho	5/31/30 19

20. Undertaker Hall Mortuary, Pocatello, Ida Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71301

PLACE OF DEATH

County of Bannock
City of Pocatello.

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5862
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nicholas Lopez
(a) Residence. No. 306 North Third St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

12P

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE: 35 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Engine hostler.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Angina Calientes Mexico

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Old Mexico
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Old Mexico.

14. Informant (Address): Mrs Peta Lopez
Pocatello, Idaho.

15. Filed 7/14, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 5th. (Month) 1930 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-4, 1930, to 7-5, 1930
that I last saw him alive on 7-5, 1930
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tuberculous
Peritonitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical finding
(Signed) [signature], M. D.
7/14, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho
Date of Burial: July 7. 1930

20. Undertaker: H. L. McHan, Pocatello, Idaho.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED AUG 13 1930

DO NOT WRITE IN THIS SPACE
State File No. 71302

PLACE OF DEATH
County of Bannock
City of Pocatello.

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5863
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME John ~~Bamer~~ Bonner
(a) Residence. No. 1224 North Garfield. St. ...
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. J. ~~Bamer~~ Bonner

6. DATE OF BIRTH (month, day and year): Sept. 4, 1857

7. AGE: 72 yrs. Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Machinest
(b) General nature of industry, business, or establishment in which employed (or employer): Machineal
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): British Isles. N.C.

PARENTS

10. NAME OF FATHER: Edgan ~~Bamer~~ Bonner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Eleanor Cassedy
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant (Address): E. H. Miley. 530 N. Harrison.

15. Filed 7/14, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 6, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 6, 1930
that I last saw him alive on July 6, 1930
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W. W. Brother M. D.
7-14, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Mt. View. Cemetery. Date of Burial: 7/8.9 19

20. Undertaker: H. L. McHan. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71303

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5864

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Hilda Marie Cushing

(a) Residence. No. 1415 North Harrison Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of C. S. Cushing

6. DATE OF BIRTH (month, day and year): July 2, 1877.

7. AGE

Years	Months	Days	If LESS than 1 day,
53	0	11	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Carl Ohlin

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: C. S. Cushing

(Address) 1415 North Harrison Ave.

15. Filed 7/14/30., 19__ [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13, (Day) 1930. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to July 13, 1930

that I last saw her alive on July 13, 1930

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia left

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Delayed resolution

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. W. Brothers M. D.

7/13/30., 19__ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.

Date of Burial: 7/15/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71301

PLACE OF DEATH
County of Bannock
City of Pocatello

CERTIFICATE OF DEATH
Registration District No. 28
Primary Registration District No. 211 Local Registrar's No. 2262
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. **FULL NAME** Annie C. Fox

(a) Residence. No. 803 East Clark St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John C. Fox

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Wm. Benjamin La Rue
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Sarah J. Richards
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant (Address) John C. Fox

15. Filed 7/4 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 14, 1930
that I last saw her alive on July 14, 1930
and that death occurred, on the date stated above, at 12 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of breast

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Carcinoma
(Signed) John C. Fox, M. D.
July 14 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cemetery	7/16 1930

20. Undertaker H. L. McHan Address Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Roll

FORM V. S. No. 5-25 M. 1-19

RECEIVED AUG 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2161

File No. 71305

Registered No. 5866

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Borscheid Chapman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

48 Dec (Month) 16 (Day) 1882 (Year)

7. AGE

47 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER John Borscheid

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Gesberg

13. BIRTHPLACE OF MOTHER (State or Country) Iowa City Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leon Chapman

(Address) Blackfoot, Ida.

15.

Filed Aug 1 1930

Dr. J. R. Lyman M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/15/30 19..., to July 18 1930, that I last saw h[er] alive on July 18 1930, and that death occurred on the date stated above, at 7:05 P.M.

The CAUSE OF DEATH* was as follows:

Operation for bilateral salpingitis -

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Septicaemia

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) H. C. Lyman M. D.

7/18 1930 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Don't know

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Blackfoot Ida — **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER E. T. Rich — **ADDRESS** .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2161

File No. 71306

Registered No. 5867

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nelda L Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1891 (Year)

7. AGE: 38 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ouray Colorado

10. NAME OF FATHER: Jay J. Rass

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Grace Eaby

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martin E Miller

(Address) Fort Hall

15. Filed Aug 1 1930 Dr. J. R. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 19 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1930 to July 19 1930 that I last saw her alive on July 19 1930, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ..... Yrs. ..... mos. 24 ds.

Contributory (Secondary) Ruptured Salpingitis

(Duration) ..... yrs. ..... mos. 24 ds.

(Signed) W. H. Lyman M. D.

7-26 1930 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 21 days. In the State 16 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? NR

Former or usual residence Fort Hall Idaho

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho — DATE OF BURIAL: July 21 1930

20. UNDERTAKER: E T Funk — ADDRESS: E T Funk

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71307

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5868

92

2. FULL NAME Ralph Ballard

(a) Residence. No. 527 West Carson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Margorie Dickisson

6. DATE OF BIRTH (month, day and year) October 17, 1899.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	30	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Brakemen
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country): Payson, Utah.

PARENTS

10. NAME OF FATHER: J. N. Ballard
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Payson, Utah.
12. MAIDEN NAME OF MOTHER: Mary Huff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rich County, Utah.

14. Informant: Mrs. Ralph Ballard
(Address) 527 West Carson St. Poca., Ida.

15. Filed 7/26/30. 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 7-19, 1930, to 7-25, 1930
that I last saw h[illegible] alive on 7-25, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) [illegible] yrs. [illegible] mos. [illegible] ds.
CONTRIBUTORY (Secondary) Superficial abscess
(duration) ____ yrs. ____ mos. 5 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 7/21/30
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [signature] M. D.
7/26/30. 19____ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Victor, Idaho.	7/27/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71308

PLACE OF DEATH

County of Bannock

City of Pocatello Idaho

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5869

(No. General Hospital Pocatello)
(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Carl H. Babb

(a) Residence. No. Near Aberdeen, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 22nd 1909

7. AGE: Years 21, Months 6, Days 3. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bert Sroschein

9. BIRTHPLACE (city or town) (State or country): Dalton Neb

PARENTS

10. NAME OF FATHER: B.B.Babb

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Effie A. Selders

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: B. B. Babb
(Address) Aberdeen, Idaho

15. Filed 7/25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 25, 1930 that I last saw him alive on July 25, 1930 and that death occurred, on the date stated above, at 10:31 P m.

The CAUSE OF DEATH* was as follows: Fracture of 5 & 6 cervical vertebrae dislocation of 6th with endent crushing or severance of cord (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Injured by striking head on bottom of canal (duration) ___ yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) A.M. Newton M.D. M. D.

July 25, 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Aberdeen, Idaho — Date of Burial: 7/28/30

20. Undertaker: Aro Davis — Address: American Falls, Ida

RECEIVED OCT 31 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS

LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

71368

Dr. A.M. Newton
Pocatello

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

Carl H. Babb who died at Pocatello, Idaho on July 25, 1930
Cause of death "Fracture of 5 & 6 cervical vertebrae dislocation of 6th with evident crushing or severance of cord.

Information DESIRED in order to complete certificate:

WHAT KIND OF AN ACCIDENT WAS THE PRIMARY CAUSE OF DEATH. IF AUTO PLEASE STATE WHERE ACCIDENT OCCURRED.

PLEASE ANSWER BELOW:

Mr Babb was injured by striking head in bottom of canal while diving

A.M. Newton M.D.

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71309

PLACE OF DEATH

County of Bannock.
City of Pocatello.

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 216/
Local Registrar's No. 5870
(No. Lynn Bro. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** William Spencer Derrick.

(a) Residence. No. 911 So. First. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Colored	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Selita Ashford.

6. DATE OF BIRTH (month, day and year) Dec. 27, 1874.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55.	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Reporter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Unknown
(State or country) Ohio.

PARENTS

10. NAME OF FATHER Derrick.

11. BIRTHPLACE OF FATHER (city or town) Unknown.
(State or Country)

12. MAIDEN NAME OF MOTHER Susie.

13. BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or County)

14. Informant Mrs. Selita Ashford.
(Address)

15. Filed 7/26, 1930 H. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 26. (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 26, 1930
that I last saw h[illegible] alive on July 26, 1930
and that death occurred, on the date stated above, at 7 9 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Chronic Interstitial
Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? physical Exam

(Signed) A. Lynn, M. D.
7/26/30 19 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Larami Wyo.	
20. Undertaker	Address
H.L. McHan.	Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71310

PLACE OF DEATH
County of Bannock
City of Inkom

Registration District No. 28
Primary Registration District No. 2161
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5871

90

2. FULL NAME Ruth H Horton,
(a) Residence. No. Residence South of Inkom St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jewell Horton Jr.

6. DATE OF BIRTH (month, day and year): October 1 1905.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
24	9	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Honneyville Utah

PARENTS

10. NAME OF FATHER: Enoch Hunsaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Brigham City Utah
12. MAIDEN NAME OF MOTHER: Ellen May
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Call's Fork Utah

14. Informant: Mrs Chris Kiilsgaard
(Address): Inkom

15. Filed 7-29, 1930 Dr. J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 28. 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from about June 1, 1930, to July 28, 1930
that I last saw her alive on July 27, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
"Heart failure"

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Obstruction common duct Cerifyeus gall bladder

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of 6-7-30
Was there an autopsy? No
What test confirmed diagnosis? Finding at operation
(Signed) [signature], M. D.
7/29, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Honneyville Utah
Date of Burial: July 30 1930

20. Undertaker: Hall Mortuary
Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 13 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 216

(No. St. Anthony's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71311

Local Registrar's No. 5872

160

2. FULL NAME Arthur R. Woodvine

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	0	0	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Arthur J. Woodvine

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rexburg, Idaho.

12. MAIDEN NAME OF MOTHER Ruby Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rigby, Idaho.

14. Informant Arthur J. Woodvine

(Address) 508 West Halliday, Poca., Idaho.

15. Filed 8/2/30., 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 2, (Day) 1930, (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 2, 1930, that I last saw h__ alive on July 1, 1930, and that death occurred, on the date stated above, at 6 6 m.

The CAUSE OF DEATH* was as follows:

Jaundice Neonatorum

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? no

(Signed) O. F. Hall M. D.

8/2/30., 19____ (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	8/2/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7131?

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5873
(No. 339 South Third Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

180a

2. FULL NAME Fay Annetta Hancock

(a) Residence. No. 339 South Third Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 8 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 15, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	8	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Elijah Hancock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Downey, Idaho.
12. MAIDEN NAME OF MOTHER Mildred Mary Egbert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Perry, Idaho.

14. Informant Elijah Hancock
(Address) 339 South Third Ave. Poca., Ida.

15. Filed 8/5/30. 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 3, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to Aug 3, 1930
that I last saw her alive on Aug 3, 1930
and that death occurred, on the date stated above, at 11 30 p.m.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) Pertussis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
8/4/30. 19 (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Turner, Idaho.	8/5/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

RECEIVED AUG 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71313

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Lynn Brothers Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5874

1000

2. FULL NAME Anita Faye Bybee

(a) Residence. No. North of Pocatello City. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 7 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 6, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	7	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Ellis A. Bybee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pocatello, Idaho.
12. MAIDEN NAME OF MOTHER Lydia Marley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) McCammon, Idaho.

14. Informant Ellis A. Bybee
(Address) North of Pocatello City

15. Filed 8/5/30., 19.. J. F. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 4, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 3, 1930, to aug 4, 1930
that I last saw her alive on aug 4, 1930
and that death occurred, on the date stated above, at 10½ a. m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) whooping Cough
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis Phy Examination
(Signed) J. F. Young, M. D.
8/4/30., 19.. (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	8/6/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71314

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. 6th & Railroad Ave
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME John Williams 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 80 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Dog catcher
(c) Name of employer: City of St. Maries

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: G. Espe
(Address): St Maries

15. Filed July 15, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Heart-block
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. Espe Coroner, M. D.
6/16/30, 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida | Date of Burial: 6-17 1930

20. Undertaker: G. E. Mitchell | Address: St Maries

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 11 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 71315
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pat Lucey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 79 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dr. C. A. Robins
(Address) St Maries

15. Filed July 15 1930 Walter Boberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH

45

16. DATE OF DEATH June (Month) 21" (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/1 1930, to 6/21 1930, that I last saw him alive on 6/21 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Ca. of Colon

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

6/21 1930 (Signed) C A Robins M. D.
(Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 37 days. In the State ..... yrs. ? mos. ..... days
Where was disease contracted if not at place of death? Ca. Lawson Alder Creek
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries Ida
DATE OF BURIAL: June 23 1930

20. UNDERTAKER: Geo E. Mitchell
ADDRESS: St Maries

SYMS - YORK CO., PTRS. & BORS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71316

PLACE OF DEATH

County of Benewah

City of St. Maries, Ida.

Registration District No. 32

Primary Registration District No. 2 or 9

Local Registrar's No. 28

(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1997

2. FULL NAME John Lee

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	10	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Loggers

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) .....
(State or country) Miss

PARENTS

10. NAME OF FATHER Geo W Lee

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Texas

12. MAIDEN NAME OF MOTHER Almira C Hysters

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Kentucky

14. Informant Mrs O K Lee
(Address) Worley Idaho

15. Filed Aug 18 1930 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
7/8, 1930, to 7/9, 1930
that I last saw him alive on 7/9/, 1930
and that death occurred, on the date stated above, at 5:18 A.m.

The CAUSE OF DEATH* was as follows:
Traumatic Shock
Industrial accident. Log rolled over body. Accidental.
(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Fractures of spine & pelvis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) D E Bonnwell, M. D.
7/9, 1930 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain Hope Work	July 11 1930
20. Undertaker	Address
Geo Mitchell	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71317

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Espe Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

101a

2. FULL NAME Mike King

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 58 Months – Days – If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER Nick Koring
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Caroline Abrunt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John G Koring
(Address) Albures Cal

15. Filed Aug 8 – 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-26, 1930, to 7-27, 1930
that I last saw him alive on 7/27/30, 19..
and that death occurred, on the date stated above, at 3:15 a m.
The CAUSE OF DEATH* was as follows: Pneumonia acute Labor

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G G Espe M. D.
7/29, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shakopee Minn
Date of Burial 19

20. Undertaker Geo E Mitchell
Address St Maries

Delayed Complete

Jan. 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 9 1930

DO NOT WRITE IN THIS SPACE

State File No. 71320

PLACE OF DEATH — **CERTIFICATE OF DEATH**

County of Ft. Hall Reser'wn Registration District No. I2I

City of Idaho. Primary Registration District No. 2I94-R Local Registrar's No. 97

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jim Pamboah 81

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind? 4/4

5. Single, Married, Widowed, or Divorced (write the word.): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: - Tahm*-

6. DATE OF BIRTH (month, day and year): - I852--

7. AGE: Years 78 | Months -- | Days -- | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant (Address): Jimmie Beaver, Ft. Hall, Idaho

15. Filed July I5, 1930 Mrs Walter E. Patrick, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 2I, I930 (Month) (Day) (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from July 2I, 1929, to Jan 2I, I930, that I last saw him alive on Jan. I0, I930, 19.. and that death occurred, on the date stated above, at 5. P m

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

..... (duration) ..... yrs. 6 mos. ..... ds

CONTRIBUTORY (Secondary) --

..... (duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys signs

(Signed) Henry R. Wheeler, M. D

....., 19.. (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal: Bannock Creek Cem. Ft. Hall Reservation, I/24/30 — Date of Burial 19..

20. Undertaker: Jim Jack, Pauline, Idaho. — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Current Complete — **May 1930**

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 9 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71321

PLACE OF DEATH

County of Ft. Hall Res'vn. Registration District No. 121

City of Idaho Primary Registration District No. 2194-R Local Registrar's No. 98

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tinnotse Shay

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jim Shay

6. DATE OF BIRTH (month, day and year) - 1870-

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Jim Shay, Jr. Ft. Hall, Idaho

15. Filed July 15 1930 Mrs. Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to May 2, 1930, that I last saw her alive on May 1, 1930, and that death occurred, on the date stated above, at 11. A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) yrs. 4 mos. - ds.

CONTRIBUTORY --- (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Henry R. Moeller, M. D.

19..... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Bannock Creek Cem.	5/5/30 19

20. Undertaker ---------

Address

Current Complete

May 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71322

RECEIVED AUG 9 1930
PLACE OF DEATH

County of Ft. Hall Res'vn. Registration District No. 121

City of Idaho Primary Registration District No. 2194-R. Local Registrar's No. 99

(No.) 1000

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Eagle

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Eagle Eye

6. DATE OF BIRTH (month, day and year) 1819

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	III	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Charlie Eagle
(Address) Ft. Hall, Idaho

15. Filed July 25, 1930 Mrs. Walter E. Pettis Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930 to May 10, 1930
that I last saw her alive on May 9, 1930
and that death occurred, on the date stated above, at 9:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia- bronchial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Henry R. Miller M. D.
, 19 (Address) Ft. Hall, Idaho

19. Place of Burial, Cremation, or Removal: Ross Creek Cemetery Ft. Hall Reservation, 5/12/30 — Date of Burial 19

20. Undertaker: Shoemaker & Beasley, Pocatello. — Address

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back. Exact statement of OCCUPATION is very important.

RECEIVED AUG 9 1930

Current Complete May 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71323

PLACE OF DEATH

County of Ft.Hall Res'vn. Idaho. Registration District No. 121

City of ..... Primary Registration District No. 2194-R Local Registrar's No. 100

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Quagigant

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----

6. DATE OF BIRTH (month, day and year) ----

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	--	--	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Frank Quagigant

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Ida Pahneeno

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant Ida Quagigant,
(Address) Ft.Hall, Idaho

15. Filed July 25, 1930 Mrs. Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1930, to May 28, 1930,
that I last saw him alive on May 28, 19....
and that death occurred, on the date stated above, at 3:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Obstruction of Bowels

2 Days
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Walter, M. D.
....., 19.... (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery Ft.Hall Reservation,	5/30/30 19

20. Undertaker Agency Carpenter, Address Ft.Hall, Ida

N. B.—Every item of information should be carefully supplied. NONE should be stated. PROVISION should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Current Complete April 1930

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71321

PLACE OF DEATH

County of Bingham Registration District No. 12I

City of Blackfoot Primary Registration District No. 1007-R Local Registrar's No. 101

(No. County Hospital, ~~W~~ Judicial St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sam Mosho

(a) Residence. No. Ft. Hall Reservation. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Peood Silver

6. DATE OF BIRTH (month, day and year) - 1860--

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation.

PARENTS

10. NAME OF FATHER Mosho

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER Ah-dimpt

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft. Hall Reservation

14. Informant (Address) Mrs. Garfield Pocatello, Pauline, Idaho

15. Filed July 25, 1930 Mrs Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930 to Apr. 1, 1930
that I last saw him alive on Apr. 1, 1930
and that death occurred, on the date stated above, at 8:30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Auto Accident: Fract. L. Tibia & fibula and humurus. Fracture of base of skull. Lacerated foot. Auto ran into deceased wagon on State Highway 4 miles S. Blackfoot

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. Opinion
(Signed) Henry R. Wheeler M. D.
, 19 (Address) Ft. Hall, Idaho

19. Place of Burial, Cremation, or Removal: Bannock Creek Cemetery — Date of Burial: 4/4/30

20. Undertaker: Modern Mortuary — Address: Blackfoot, Idaho

N. B.—Every item of information should be carefully supplied. And should be stated EXACTLY. PHRASING should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Current Comple

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

April 1930

DO NOT WRITE IN THIS SPACE

State File No. 71325

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation, Idaho Registration District No. 121

City of ..... Primary Registration District No. 2194-R . Local Registrar's No. 102

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Moreock -----

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Widpw

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of -- Sampson--

6. DATE OF BIRTH (month, day and year) 1838

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	92	---	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Nevada (State or country)

PARENTS

10. NAME OF FATHER Con-ne-house

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Sah-quah-zah-hah

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nevada

14. Informant Tom Penn
(Address) Ft. Hall, Idaho

15. Filed July 25, 1930 Mrs. Walter E. Patrie
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29, 1930
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 9:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

..... (duration) ..... yrs. 9 mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler M. D.

....., 19..... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal: Presbyterian Mission Ft. Hall Reservation, 5/2/30 — Date of Burial 19

20. Undertaker: Agency Carpenter, Ft. Hall, Idaho — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

Ft.Hall Jurisdiction

PLACE OF DEATH

Current Complete

June I930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71326

County of Ft.Hall Reservation, Idaho.* Registration District No. I2I

City of ..... Primary Registration District No. 2I94-R Local Registrar's No. 103

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME Fred Wadzese

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Comfort McKean

6. DATE OF BIRTH (month, day and year) -- I882--

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Wadzese

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft.Hall Reservation

12. MAIDEN NAME OF MOTHER To-hoy-ah

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft?Hall Reservation

14. Informant (Address) Comfort McKean Ft.Hall,Idaho

15. Filed July 25, 1930 Wm. Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4, I930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 4, I93,0
that I last saw him alive on June,4, I930, 19..
and that death occurred, on the date stated above, at 9:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

7 Days
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Phys.Signs

(Signed) Henry R. Wheeler M. D.
..... 19.. (Address) Ft.Hall,Ida

19. Place of Burial, Cremation, or Removal: Butte Cemetery Ft.Hall Reservation, 5/7/30 — Date of Burial 19

20. Undertaker: Brown-Eldredge,Blackfoot,Ida. — Address

RECEIVED AUG 9 1930 Current Complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

June 1930

DO NOT WRITE IN THIS SPACE
State File No. 71327

Ft.Hall Jurisdiction
PLACE OF DEATH

County of Ft.Hall Reser'vn. Registration District No. 121
City of Idaho. Primary Registration District No. 2194-R . Local Registrar's No. 104
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Bache

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elmira Katawa

6. DATE OF BIRTH (month, day and year) -- 1869--

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Elmira Katawa, P.O.
(Address) ---

15. Filed July 25, 1930 Wm. Walter E. Pahis
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 9, 1930
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11: P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy- cerebral

One day.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) , M. D.
, 19 (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cemetery Ft.Hall Reservation,	6/12/30 19

20. Undertaker	Address
Brown-Eldredge,	Blackfoot, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

Current Complete

June 1930

Ft.Hall Jurisdiction

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71328

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft.Hall Reservation, Idaho. Registration District No. 121

City of ..... Primary Registration District No. 2194-R . Local Registrar's No. 105

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Ahvono Dunn

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Bannock Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John Dunn

6. DATE OF BIRTH (month, day and year) --1846--

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Mollie Phelps
(Address) Ft.Hall, Idaho

15. Filed July 25, 1930 Wm. Walter E. Patrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 16, 1930
(Month) (Day) (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 1:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Nephritis- chronic

.....(duration) 2 yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Henry R. Wheeler M. D.

....., 19..... (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal: Portneuf Cemetery, Ft.Hall Res'vn — Date of Burial: 6/18/30 19

20. Undertaker: Brown-Eldredge, Blackfoot, Ida — Address

... Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71329

PLACE OF DEATH
County of Bingham
City of ~~Blackfoot.~~ Rose Prench.
Registration District No. 121
Primary Registration District No. 2196
(No.)
Local Registrar's No. 106
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anton H. Kruse,
(a) Residence. No. Blackfoot Rt. 1. St.
(Usual place of abode)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Zina H. Chapman Kruse

6. DATE OF BIRTH (month, day and year) Sept. 14. 1890

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	9	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer and labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Blackfoot Milling Co.

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Theodore Kruse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Berlin, Gr.
12. MAIDEN NAME OF MOTHER Anna Clara
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Zina H. Kruse
(Address) Blackfoot, Ida.

15. Filed July 5, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July. 4. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 4, 1930
that I last saw h~~im~~ alive on July 4, 1930
and that death occurred, on the date stated above, at 2.30 A. m.
The CAUSE OF DEATH* was as follows:

Myocardites. Streptocous

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Toxic Goitre
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.
July 5, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	4-6-1930
20. Undertaker	Address
Modern Mortuary,	Blackfoot. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71330

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2191
Local Registrar's No. 107
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

34

2. FULL NAME MILDRED SHAFFER

(a) Residence. No. Hagerman Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

~~Butte, Montana~~
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clyde Shaffer

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Butte, Montana

PARENTS

10. NAME OF FATHER Benjamin Hipp,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Grace A Clippinger
(Address) Blackfoot, Ida.

15. Filed July 6, 1930 Mrs Walter E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5th, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 15th, 1930 to July 5th, 1930
that I last saw her alive on July 5th, 1930
and that death occurred, on the date stated above, at 12:45 P m.
The CAUSE OF DEATH* was as follows:

SYPHILIS

Don't know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
July 5th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dove City Cem	7-7- 1930
20. Undertaker	Address
Modern Mortuary	Bfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71332

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 109

101A

PLACE OF DEATH

County of Bingham

City of Blackfoot

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melcena V. Hall.

(a) Residence. No. Blackfoot, Ida. Rich Lane St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. T. Woodland

6. DATE OF BIRTH (month, day and year) Dec. 23. 1850

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79-	8	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10. NAME OF FATHER Pettes W. Sims

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.

12. MAIDEN NAME OF MOTHER Sarah T. Kersey

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va.

14. Informant Mrs J. T. Woodland

(Address) Blackfoot, Ida.

15. Filed July 10, 1930. Mrs Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July July 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 9, 1930, that I last saw h-- alive on July 9, 1930, and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical examination

(Signed) H. K. Eagan M. D.

July 10, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	8-11-30 19

20. Undertaker	Address
Modern Mortuary,	Blackfoot, Ida.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... , ... St.)

File No. 71333

Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H Fayle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1870 (Year)

7. AGE: 59 Yrs. 6 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stockman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wellsville Utah

10. NAME OF FATHER: Wm Fayle

11. BIRTHPLACE OF FATHER (State or Country): Isles of Man

12. MAIDEN NAME OF MOTHER: Elizabeth Heaton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret J Noyes

(Address) Dubois Idaho

15. Filed July 12 1930 Mrs. Walter E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1930 to July 11 1930 that I last saw him alive on July 11 1930, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. U. Mitchell M. D.

7/12 1930 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho

DATE OF BURIAL: Jun 13 1930

20. UNDERTAKER: E J Peck

ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71334

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 111

(No.) 161A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LaRue Ormond

(a) Residence. No. Blackfoot, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 14, 1930

7. AGE: Years | Months | Days | If LESS than 1 day, hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot Idaho

PARENTS

10. NAME OF FATHER: Thos. William Ormond
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Eureka Utah
12. MAIDEN NAME OF MOTHER: Selena Reiser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake Utah

14. Informant: J W Ormond
(Address) Blackfoot R-3

15. Filed July 14 1930 Mrs. Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 14, 1930
that I last saw her alive on July 14, 1930
and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
6 Ct month
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
July 14, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: L. C. Cem Blackfoot — Date of Burial: 6-15 1930

20. Undertaker: J W Ormond Acting — Address: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19

RECEIVED AUG 9, 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Shelley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 71335

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florencia Mendoza

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Informant does not know (Month) (Day) (Year)

7. AGE: 46 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farm Laborers

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico.

10. NAME OF FATHER: Donicio Mendoza

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Petra - ? -

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. Regalado

(Address) Shelley, Ida

15. Filed Aug 1 1930 Mrs Walter E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-15- 1930, to 7-15- 1930 that I last saw him alive on 7-1- 1930 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edwin Crotter M. D.

7-15 1930 (Address) Shelley Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? New Mexico

Former or usual residence New Mexico

19. PLACE OF BURIAL OR REMOVAL: Lincoln Id.

DATE OF BURIAL: 7-15 1930

20. UNDERTAKER: None

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71336

PLACE OF DEATH
County of Bingham
City of Pingree Rt 1.
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 113
(No. 198)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Major Godfrey Ropp
(a) Residence. No. Pingree, Rt 1. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or ~~WIFE of~~) Sarah Emmeline White
6. DATE OF BIRTH (month, day and year) Nov 6, 1856
7. AGE: Years 73 | Months 8 | Days 11 | If LESS than 1 day, ____ hrs. or ____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Self
9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10. NAME OF FATHER: William Ropp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Elizabeth Wolford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Tom Ropp
(Address) Pingree, Rt 1.
15. Filed July 18, 1930 Wm. Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1-10, 1930, to 7-17, 1930
that I last saw him alive on 7-15, 1930
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with Hypertension
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) J. O. Thompson M. D.
7-18, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem. — Date of Burial: July 19 1930
20. Undertaker: E. J. Peck — Address: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71327

Registered No. 71327

1. PLACE OF DEATH

County of Bingham

City of Blackfoot Ida,

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. 291 No. Shilling Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Owen H. Cherrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH: July (Month) 13 (Day) 1868 (Year)

7. AGE: 62 Yrs. 3 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Austin Cherrington

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Susana Myers

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. [redacted] Cherrington

(Address) 29[redacted] Shilling, Blackfoot

15. Filed July 19 1930 Mrs Walter E. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1930 to July 17 1930 that I last saw h[redacted] alive on July 17 1930, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic

(Duration) 2 Yrs. 1 mos. ds.

Contributory (Secondary) Dropsy

(Duration) 6 mos. ds.

(Signed) H. W. Mitchell M. D.

7/18 1930 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green Lawn Cemetery DATE OF BURIAL: July 20 1930

20. UNDERTAKER: E. J. Funk ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121

Primary Registration District No. 1007

File No. 71328

Registered No. 715

1. PLACE OF DEATH

County of Bingham

City of Blackfoot, Ida. (No. 60 Pine Street St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura E. Younie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	widow

6. DATE OF BIRTH July (Month) 26 (Day) 1847 (Year)

7. AGE 82 Yrs. II Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER James Elliott

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Phelly Tayler

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nettie Boyle.

(Address) Blackfoot

15. Filed July 21 1930 Mrs Walter E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

44

16. DATE OF DEATH July (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-18 1930, to 7-20 1930

that I last saw h.. alive on 7-19 1930

and that death occurred on the date stated above, at 4 p. M.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach & myocardites

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hamptein M. D.

7-21 1930 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL From city cemetery — **DATE OF BURIAL** July 22 1930

20. UNDERTAKER E. J. Funk — **ADDRESS** Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71339

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 116

75

2. FULL NAME S. L. Morrow

(a) Residence. No. ..... St. Council, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2½ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): WIDOWED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 79 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: ---

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10. NAME OF FATHER: ----
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ---
12. MAIDEN NAME OF MOTHER: ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ---

14. Informant Harold Goldsworthy Att.
(Address) Blackfoot, Idaho

15. Filed July 22, 1930 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July ~~June~~ 21st, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 12th, 1930, 19 to July 21st 1930, 19
that I last saw him alive on July 20th, 1930, 19
and that death occurred, on the date stated above, at 5:30A m.
The CAUSE OF DEATH* was as follows:
General Paralysis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams, M. D.
July 21st, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Asylum Cemetery | Date of Burial: July 22 1930

20. Undertaker Acting Marion Clark | Address Blackfoot

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 9 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 1007

(No. 163 No. Shilling Ave St.)

File No. 71340

Registered No. 118

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosabelle Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: June (Month) 25 (Day) 1865 (Year)

7. AGE: 65 Yrs. 1 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Eschr. W. Shurtliff

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Elsamina Shurtliff

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lulu Y. Hansen

(Address) Blackfoot Idaho

15. Filed July 26 1930 Mrs Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH: July 25 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1929 to July 25 1930 that I last saw her alive on July 25 1930 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Senile Dementia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

7/26 1930 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Geom City Cemetery

DATE OF BURIAL: July 27 1930

20. UNDERTAKER: E. F. Luck

ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71341

PLACE OF DEATH

County of Bingham
City of Blackfoot.

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

44

2. FULL NAME Emily A. Walters,

(a) Residence. No. Blackfoot, Thomas Rt. 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Walters

6. DATE OF BIRTH (month, day and year): AUG. 16, 1858

7. AGE: Years 71, Months 11, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: James Bateman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Emily Argent
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Myrtle Walters
(Address) Blackfoot Ida.

15. Filed Jul 29, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July, 27, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1928 to July 27, 1930
that I last saw her alive on July 27, 1930
and that death occurred, on the date stated above, at 4:15P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach + Liver
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical examination + symptoms
(Signed) W. H. Eagan M. D.
July 28, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside-Thomas Cem. Date of Burial: 8-30-30 19

20. Undertaker: Modern Mortuary, Ida. Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete June 1930

REGEIVED AUG 9 1930

Ft. Hall Jurisdiction

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71342

PLACE OF DEATH

County of Beaver Head Montana
City of Near Lima

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

199

2. FULL NAME George Tendoy

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Toegatse Gunn

6. DATE OF BIRTH (month, day and year) ** 1863**

7. AGE Years 67 Months -- Days -- If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lemhi Reservation

PARENTS

10. NAME OF FATHER John Tendoy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Tune-gog-go

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lemhi Reservation

14. Informant (Address) Arthur Tendoy Ft. Hall, Idaho

15. Filed Jul. 25, 19 30 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25, 1930 (Month) (Day) (Year), 19....
No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Fracture at base of skull.
(Murdered)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Henry R. Wheeler M. D.
....., 19.... (Address) Ft. Hall, Idaho

19. Place of Burial, Cremation, or Removal. Presberyterian Mission Ft. Hall Reservation, Date of Burial 6/28/30 19

20. Undertaker Brown-Eldredge, Blackfoot, Ida Address

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930 Current Complete June 1930

Ft. Hall Jurisdiction

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. .....

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Beaver Head Montana. Registration District No. .....

City of Near Lima Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Tendoy

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Toegatse Gunn

6. DATE OF BIRTH (month, day and year): ** 1863 **

7. AGE: Years 67 | Months -- | Days -- | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS

10. NAME OF FATHER: John Tendoy

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Tune-gog-go

13. BIRTHPLACE OF MOTHER (city or town) (State or County): Lemhi Reservation

14. Informant (Address): Arthur Tendoy, Ft. Hall, Idaho

15. Filed Jul. 25, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 25, 1930 (Month) (Day) 19.... (Year)

No Doctor attending

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

that I last saw h..... alive on ....., 19....

and that death occurred, on the date stated above, at 9:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Fracture at base of skull.

(Murdered)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Amy R. Wheeler, M. D.

....., 19.... (Address) Ft. Hall, Idaho

19. Place of Burial, Cremation, or Removal: Presberyterian Mission, Ft. Hall Reservation, 6/28/30 — Date of Burial 19

20. Undertaker: Brown-Eldredge, Blackfoot, Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

W. E. PATRIE
PHYSICIAN AND SURGEON

Blackfoot, Idaho,
Aug.2, 1930

Hon. C.K.Macey,
Com'sr Public Welfare,
Boise,Idaho.

Dear Sir:

The enclosed Indian births and deaths are copies from Dr.Henry R.Wheeler's originals which he forwards to the Department of Commerce at Washington D.C., or the Indian Department.

It occurred to me that perhaps you desired a record considering that this death was the result of an unprovoked and brutal murder the perpetrator of which has not been apprehended.

Tendoy with his family was camped near the roadside a very few miles north of the Idaho State line and was visited by a party of foreigherns and beaten by a neck-yoke or bludgeon. His family instead of appealing to Montana authorities brot the body to the reservation and appealed to our Bingham County officers, after two days drive by horse and wagon in hot weather.

The facts as stated above is as stated by Mr. Ray Mc.Clelland, Bingham County Coroner.

This death occured in Montana, and I believe that no certificate of this death is on file in Montana.

I did not record the Tendoy death.

Yours truly,
Mrs Walter E. Patrie
Local Registrar.

P.S. The cause of death is incomplete. Dr.Wheeler is acquainted with the circumstances of the murder and the same should be indicated on the returns.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71344

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 54

PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Dock.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

64

2. FULL NAME Pete Kimberly

(a) Residence. No. City Dock St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant L. G. Moon.
(Address) Sandpoint

15. Filed July 10, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th, 1930 to July 8th, 1930
that I last saw him alive on July 8th, 1930
and that death occurred, on the date stated above, at 3:30 P m.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Shock from near drowning (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. B. Graves, M. D.
July 9, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
County Plot, Pinecrest	July 10 1930
20. Undertaker	Address
L. G. Moon	Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 8 1930

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71345

Local Registrar's No. 5-8

74A

2. FULL NAME Tom Choeck

(a) Residence. No. Hope Ida. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Yellow	Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) China

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) China

14. Informant Louis Den

(Address) Hope Idaho

15. Filed July 9, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1930 to July 9, 1930

that I last saw ~~him~~ alive on July 8, 1930

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatism

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd C. Kendle, M. D.

July 9, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pinecrest Cemetery — Date of Burial: July 10 1930

20. Undertaker: Moon Mortuary — Address: Sandpoint Ida

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71346

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2155
(No. 1½ mile South End of Wagon)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

149 C

2. FULL NAME Dorothy Rhue Gault

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 27 1926

7. AGE	Years	Months	Days	If LESS than 1 day,
	4	0	12	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Spokane

PARENTS

10. NAME OF FATHER Fremont Gault.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Portland Oregon

12. MAIDEN NAME OF MOTHER Rhue Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida.

14. Informant Fremont Gault.
(Address) city.

15. Filed 7-11, 1930 Floyd A. Wood
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at about 1:30 A. m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism.
Auto Accident.
On North & South Highway
½ mile South
Duration Sandpoint Ida.

CONTRIBUTORY (Secondary) .....
.....(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) L. B. Moon Coroner
July 10, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	7/11 1930
20. Undertaker Mundell Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71347

PLACE OF DEATH
County of Bonner
City of Sandpoint.

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 57

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME David Shepherd.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec. 15, 1850

7. AGE: Years 79 | Months 4 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Portugal. All.

PARENTS

10. NAME OF FATHER: Jacob Shepherd.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown.
12. MAIDEN NAME OF MOTHER: Caroline Sutser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. C.

14. Informant: Edwin J. Shepherd.
(Address) Los Angeles Cal.

15. Filed July 19, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 15 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1930, to July 14, 1930
that I last saw him alive on July 14, 1930
and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH was as follows:
Senility resulting in Pneumonia

(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) T. J. Post M.D., M. D.
July 19, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery. Date of Burial: July 20, 1930
20. Undertaker: Moon Mortuary Address: Sandpoint Ida

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71348

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 76
Primary Registration District No. 2155
Local Registrar's No. 56
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Fred Howe

(a) Residence. No. Selle Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 4 1908

7. AGE

Years	Months	Days	If LESS than 1 day,
22	5	19	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Humbird Lbr Co

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Henry T Howe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) NY

12. MAIDEN NAME OF MOTHER Mary Schram

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Henry T Howe
(Address) Selle Ida

15. Filed July 22, 1930 Virgil Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to July 21, 1930
that I last saw him alive on July 21, 1930
and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:
Traumatism, accidental
Struck on head by falling tree

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) C F Page, M. D.
July 22, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Colburn Cemetery	7/23 1930
20. Undertaker	Address
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71350

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 60

112

2. FULL NAME CEPHUS KERWOOD

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	WHITE	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital
(Address) Sandpoint Idaho

15. Filed July 25, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 24, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to July 24, 1930
that I last saw him alive on July 23, 1930
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis Acute gastritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Seinlsky

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Floyd G. Perrault M. D.

July 25, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	July 25 1930
20. Undertaker	**Address**
R.E. Wessa	Priest River Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71351

PLACE OF DEATH

County of Banner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No. .....)
Local Registrar's No. 11

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

44

2. **FULL NAME** Edward Jacob Gugler

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 5, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodbine
(State or country) Kansas

PARENTS

10 NAME OF FATHER Jacob Gugler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant H. H. Gugler
(Address) Priest River, Ida

15 Filed July 20, 1930 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 19 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to July 19, 1930, that I last saw h~~e~~ alive on July 16, 1930, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Findings

(Signed) Harold C. Fowler (Sworn), M. D.

July 20, 1930 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	July 21, 1930
20. Undertaker	Address
Moon Mortuary	Priest River

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71352

Local Registrar's No. 7

PLACE OF DEATH

County of Bonner

City of Hope

Registration District No. 8D

Primary Registration District No. 2157

(No.) 44

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maggie Syler

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Wesley Syler

6. DATE OF BIRTH (month, day and year) Dec 12-1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	6	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER John C Farrar

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Sarah Waltz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Edith F Steely
(Address) 510 So Harrison-Garnett Rd.

15. Filed July 5, 1930 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 3, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12, 1930 to July 3rd 1930
that I last saw her alive on June 15 1930
and that death occurred, on the date stated above, at 2 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) R. B. Evans M. D.
7-5 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hope, Idaho. Date of Burial: July 5, 1930

20. Undertaker: Moon Mortuary Address: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71353

PLACE OF DEATH
County of Bonner
City of Hope

Registration District No. 80
Primary Registration District No. 2157
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Stockton Reem 90

(a) Residence. No. Hope, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct-15-1845

7. AGE Years 84 Months 8 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millworker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER Samuel Reem
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Nancy Dauey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. H. F. Root
(Address) Bonner Mont

15. Filed July 10, 1930 John Larson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-7, 1930, to July-9, 1930
that I last saw him alive on July-7, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Chronic ~~Chronic~~ Valvular heart disease: Arterio-sclerosis (duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd G. Wendle, M. D.
July-10, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hope Ida. Date of Burial July 11, 1930

20. Undertaker L. G. Moon Address Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71354

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. Spencer Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Fritz Chase.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~): Viola A. Chase.

6. DATE OF BIRTH (month, day and year): Nov 27 1877

7. AGE: Years 52, Months 8, Days 3. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): Utah.

PARENTS

10. NAME OF FATHER: John Chase.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Hanna Fuller.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Mrs. Fritz Chase
(Address) Rigby, R. 3

15. Filed 7/31, 1930 A B Eckersell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 30, 1930 that I last saw him alive on July 30, 1930 and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Gangrene appendix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 27-30

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) H D Spencer, M. D.

July 31, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 8/2/30 19

20. Undertaker: A B Eckersell Address: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71355

Local Registrar's No. 134

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No.
Primary Registration District No.
(No. I. F. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME August Garz
(a) Residence. No. St. Gilmer, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Albertine Garz, 1930

6. DATE OF BIRTH (month, day and year) August 15, 1858

7. AGE: Years 72 | Months 10 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Henry Garz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Minnie Lipke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant William Garz
(Address) Gilmer, Idaho

15. Filed Aug 2, 1930. C. E. Freeman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to June 30, 1930
that I last saw h-m alive on June 29, 1930
and that death occurred, on the date stated above, at 5-5a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder
(duration) ? yrs. ? mos. ds.
CONTRIBUTORY (Secondary) Hypertrophied Prostatitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of June 28, 1930
Was there an autopsy? no
What test confirmed diagnosis? Laboratory & Findings
(Signed) H. Clay Gates, M. D.
June 30, 1930 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Gilmer, Idaho — Date of Burial: July 2, 19-

20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71356

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2100
(No. L. U. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 139

44

2. FULL NAME Elmer Hyrum McCowin
(a) Residence. No. Lara Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nona McCowin

6. DATE OF BIRTH (month, day and year): Nov 19, 1890

7. AGE: Years 40, Months 7, Days, If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bountiful, Utah

PARENTS
10. NAME OF FATHER: T. E. McCowin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Priscilla Hayes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: T. E. McCowin
(Address) Idaho Falls, Idaho

15. Filed 7/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 3, 1930
that I last saw him alive on July 3, 1930
and that death occurred, on the date stated above, at 10-10 a m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. Dutton, M. D.
7/5/30, 1930 (Address) Ida Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ammon, Idaho
Date of Burial: July 5 1930

20. Undertaker: Jack A. Wood
Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71358

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150 Local Registrar's No. 141
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Thomas Leonard Giles

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12, 1930

7. AGE Years Months Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Harvey Giles
11. BIRTHPLACE OF FATHER (city or town) Springfield Ill.
(State or Country)
12. MAIDEN NAME OF MOTHER Bessie Davis
13. BIRTHPLACE OF MOTHER (city or town) Bristol, Ill.
(State or County)

14. Informant (Address) x G. H. Giles Idaho Falls, Idaho - RFD 2

15. Filed July 14, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14, 1930
July 14 (Month) 1930 (Day), 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 14, 1930
that I last saw him alive on July 13, 1930
and that death occurred, on the date stated above, at 7:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Blue baby

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. A. Aupperle M.D. M.D.
, 19 (Address) Idaho Falls, Ida

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial July 14/30 19

20. Undertaker None
Address

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71359

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 12 1 N 2 Local Registrar's No. 142

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Russell Goodson

100a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 5-1930

7 AGE: Years 0 | Months 6 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho Falls. Idaho

PARENTS

10 NAME OF FATHER Miles Goodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho Falls. Ida.

12 MAIDEN NAME OF MOTHER Ida Loas Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Anthony Ida

14 Informant Miles Goodson
(Address) Roberts Idaho

15 Filed July 21, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 15 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15 1930 that I last saw him alive on July 15, 1930 and that death occurred, on the date stated above, at 7 30P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

7/16, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls. | Date of Burial: 7/20 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WOOD FUNERAL HOME
273 North Ridge Ave.
IDAHO FALLS, IDAHO

DISINTERMENT PERMIT

RECEIVED
MAY 18 1971
Bureau of Vital Statistics

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of JOHN RUSSELL GOODSON

now lying buried in Rose Hill Cemetery Cemetery, in the City or Town of Idaho Falls

County of Bonneville State of Idaho, who died on the 15 day of June, 1930, Aged 0 Infant years 6 months

days, the cause of death being Pneumonia and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. J.W. West attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private private or railway conveyance

to Iona Cemetery in the City or Town of Rural County of Bonneville

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Bonneville it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

this 13th day of May, A.D. 19 71.

Permit issued to:

Jack A. Wood, Jr.
Wood Funeral Home
Idaho Falls, Idaho

W. W. Benson
by Director, Division of ~~Vital Statistics~~

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Bonneville State of Idaho, this 10th day of May 19 71.

David V. Smith, M.D.
Health Officer

Form DPH-48019

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71360

PLACE OF DEATH
County of ~~Madison~~ Bonneville
City of ~~Rexburg~~ Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 143

41

2. FULL NAME Bob E. Ricks
(a) Residence. No. Felt Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Son of Alfred T. Ricks

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 12, Months 9, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Rexburg Idaho

PARENTS

10. NAME OF FATHER: Alfred Taylor Ricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Benson Utah
12. MAIDEN NAME OF MOTHER: Ruth R. Smellie
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Rexburg Idaho

14. Informant: Alfred T. Smith
(Address)

15. Filed July 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 20, 1930
that I last saw him alive on July 20, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Septicemia
Welsh bacillus
..... (duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (Secondary) Laceration of foot by nail
..... (duration) ..... yrs. ..... mos. 9 ds.

18. Where was disease contracted if not at place of death? Felt, Idaho
Did an operation precede death? Yes Date of July 18-30
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
July 22, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Cemetary — Date of Burial: 7/22 1930

20. Undertaker: A. F. Echeverry — Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 15 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 7136
Local Registrar's No. 144

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls, Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 N 0
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Melvin Clarence Jenness

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	newborn

6. DATE OF BIRTH: July (Month) 22 (Day) 1930 (Year)

7. AGE: No Yrs. No Mos. No ds.
IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Idaho

10. NAME OF Father: Elmer F. Jenness

11. BIRTHPLACE OF FATHER (State or Country): Nashua - New Hampshire

12. MAIDEN NAME OF MOTHER: Gladys Redmon

13. BIRTHPLACE OF MOTHER (State or Country): Dillon, Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Jenness
(Address) Idaho Falls Ida

15. Filed July 23 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH 16A

16. DATE OF DEATH: July (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1930, to July 22 1930, that I last saw him alive on July 22 1930, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Premature Birth
Twin
(Duration) ..... yrs. ..... mos. 6 hrs ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
7/23 1930 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 7/23 1930

20. UNDERTAKER: V. F. McHan — ADDRESS: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 RECEIVED AUG 15 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 7136

Local Registrar's No. 141

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls, Ida.

Registration District No. 73

Primary Registration District No. 2 14-0

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Melbourne Dave Jenness

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): newborn

6. DATE OF BIRTH: July (Month) 22 (Day) 1930 (Year)

7. AGE: No. Yrs. No. Mos. No. ds.

IF LESS than 1 day how many 11 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Ida

10. NAME OF Father: Elmer F. Jenness

11. BIRTHPLACE OF FATHER (State or Country): Nashua New Hampshire

12. MAIDEN NAME OF MOTHER: Gladys Nedrow

13. BIRTHPLACE OF MOTHER (State or Country): Dillon, Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Jenness
(Address) Idaho Falls, Ida

15. Filed 7/23 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1930 to July 22 1930, that I last saw him alive on July 22 1930, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Twins

11 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

7/23 1930 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Ida. DATE OF BURIAL: July 23 1930.

20. UNDERTAKER: O. F. McHan ADDRESS: Idaho Falls Ida

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71343

PLACE OF DEATH
County of Bonneville Registration District No. 73
City of Idaho Falls Primary Registration District No. 2-1 N. -0 Local Registrar's No. 146
(No. House)
(If death occurred in a hospital or institution, give its name instead instead of street and number.) 124

2. FULL NAME Paul Houston Shattuck

(a) Residence. No. 155-6th St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. life ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): April 1 192

7 AGE: Years 8 | Months 3 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho Falls Idaho

PARENTS
10 NAME OF FATHER: Earl Shattuck
11 BIRTHPLACE OF FATHER (city or town) (State or country): Vandalia Mo.
12 MAIDEN NAME OF MOTHER: Cora M. Martin
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ft. Riley Kans

14 Informant: Earl Shattuck
(Address): Idaho Falls Ida

15 Filed July 30, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 25 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June, 1930, to June, 1930
that I last saw h[illegible] alive on July 25, 1930
and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Peritonitis
Christian Scientist in attendance until death
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Possibly acute appendicitis
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? after death + histo

(Signed) [illegible], M. D.
7/28, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls Ida
Undertaker: V. F. McFar[illegible]
Date of Burial: 7/27 1930
Address: Idaho F[illegible] Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71361

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. 25
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Harry Robert McPherson
(a) Residence. No. Arco, Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 4 yrs. X mos. X ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Althea McPherson

6. DATE OF BIRTH (month, day and year) Apr. 23 - 1880

7. AGE

Years	Months	Days	If LESS than 1 day,
50	1	6	X hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cafe owner
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS
10. NAME OF FATHER Robert B. McPherson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant (Address) Althea McPherson

15. Filed June 2, 1930 T. C. Salt Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May ~~April~~ (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to May 27, 1930
that I last saw him alive on May 27, 1930
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
(duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary) General Passive Congestion
(duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Physical
(Signed) [illegible], M. D.
June 1, 1930 (Address) Arco Ida.

19. Place of Burial, Cremation, or Removal: Mackay, Ida
Date of Burial: May 30 1930

20. Undertaker: Theo. R. Garnier
Address: Arco, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71365

PLACE OF DEATH

County of Butte

City of Clyde.

Registration District No.

Primary Registration District No.

Local Registrar's No. 24

(No. Bell Mountain Ranger Station
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Alton Deming

(a) Residence. No. Clyde at Bell Mountain Ranger Station St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White	single boy.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 4th 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	8	8	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Blackfoot Idaho.
(State or country)

PARENTS

10. NAME OF FATHER James Riley Deming

11. BIRTHPLACE OF FATHER (city or town) Idaho Falls.
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Lizzie Rosetta Gardner

13. BIRTHPLACE OF MOTHER (city or town) Benjamin
(State or Country) Utah

14. Informant Blackfoot Idaho.
(Address)

15. Filed May 20, 1930 T. Ball
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th, 1928, to May 12th, 1930
that I last saw h.. alive on May 12th 1930
and that death occurred, on the date stated above, at Clyde Idaho m.

The CAUSE OF DEATH* was as follows:

accidently drowned
in stream.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? X

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Riley Deming, M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clyde Idaho.	May 14th 1930
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71366

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129.
Local Registrar's No. 23

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvorta Coosia Hinkson

100a

(a) Residence. No. Bernice, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Steven Samuel Hinkson

6. DATE OF BIRTH (month, day and year) Jan. 18 - 1874

7. AGE Years 56 Months 3 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payette Co, Penn

PARENTS

10. NAME OF FATHER Coosia
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Steven S. Hinkson
(Address) Bernice, Idaho

15. Filed May 7, 1930. T. C. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1930, to May 6, 1930
that I last saw her alive on May 6, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchial asthma
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical exam
(Signed) I. R. Egbert M. D.
May 7, 1930 (Address) Arco Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Howe, Idaho
Date of Burial May 8, 1930

20. Undertaker Theo. R. Garnier
Address Mackay, Ida.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71367

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 22
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Wilford Boyd Orie

(a) Residence. No. 1 Arco St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 4 mos. 4 ds. 17 How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Olive Lucinda Orie

6. DATE OF BIRTH (month, day and year) 1884-12-18

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep man
(b) General nature of industry, business, or establishment in which employed (or employer) Sheep industry
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Loa Utah

PARENTS

10. NAME OF FATHER Wilford Orie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Matilda Akerlund
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant Olive Lucinda Orie
(Address)

15. Filed April 28, 1930. T. Ball Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 26th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from ——, 19—, to ——, 19....
that I last saw h..... alive on ——, 19....
and that death occurred, on the date stated above, at ——m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental death
thrown from and dragged by cart —
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ——
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of ....
Was there an autopsy? ....
What test confirmed ~~diagnosis~~? ....

(Signed) C. Emer Tucker, M. D.
Apr 28, 1930 (Address) County Coroner

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Aurora Utah	
20. Undertaker Geo. R. Harris	Address Arco, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71368

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Butte
City of Arco
Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 21
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Robert Stone Duke

(a) Residence. No. Arco Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Elizabeth VanArsdal Duke

6. DATE OF BIRTH (month, day and year) Feb 21 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo Utah

PARENTS

10. NAME OF FATHER James Duke
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Almira Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York

14. Informant Mary Duke
(Address) Kilgore Idaho

15. Filed April 14, 1930 J. C. Ball Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 12, 1930
that I last saw him alive on April 11, 1930
and that death occurred, on the date stated above, at 2 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) Dr. C. Egbert M. D
April 12, 1930 (Address) Arco Ida.

19. Place of Burial, Cremation, or Removal: Arco Idaho. Date of Burial: April 14 1930

20. Undertaker: Theo. R. Garnier Address: Mackay Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71369

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

122

2. FULL NAME Joseph P Kratzberg
(a) Residence. No. ..... St. no
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of yes.
6. DATE OF BIRTH (month, day and year) Apr 9th 1866
7. AGE 66 Years Months 3 Days 20 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER Anton. Kratzberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Anthony H. Kratzberg
(Address) Parma Idaho.
15. Filed Aug 1, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 29, 1930
that I last saw him alive on July 28, 1930
and that death occurred, on the date stated above, at 10:45 a.m.
The CAUSE OF DEATH* was as follows:
Cirrhosis of liver
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hemorrhage - Stomach
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical.
(Signed) [signature], M. D.
7/20, 1930 (Address) Nyssa Ore

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Parma Idaho. Date of Burial July 31 1930
20. Undertaker C V Peckham. Address Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71370

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 94
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. **FULL NAME** Malissa alice Lantzer

(a) Residence. No. Nampa Ida R#3 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married.

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of S W. Lantzer

6. DATE OF BIRTH (month, day and year) Oct 7-1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Adams Co. Ohio
(State or country)

PARENTS

10. NAME OF FATHER Henry May
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Margaret Mc Clung
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant (Address) Edd Lantzer Nampa, Idaho

15. Filed 8-9-, 1930. John S Rieger Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 9th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3, 1930, to Aug 8, 1930, that I last saw h 9 alive on August 8, 1930, and that death occurred, on the date stated above, at 2:12 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Ch. Gen. Nephritis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of X
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) S W Lantzer M. D.
August 9, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Aurora, Nebr.	19

20. Undertaker C. V. Peckham — Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71371

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 93
(No. Caldwell Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Elise (D.S.) Pierson

(a) Residence. No. Jerome Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

1/28

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr D S Pierson

6. DATE OF BIRTH (month, day and year) Apr 25 1908

7. AGE Years 22 Months 3 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Beaver Dam Utah

PARENTS

10. NAME OF FATHER E.P.Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Brigham Cty Utah
12. MAIDEN NAME OF MOTHER Lorentze Lundlic
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Norway

14. Informant (Address) E P Jensen Parma Ida

15. Filed 8-9-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 8-30, 19.. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930 to August 8, 1930
that I last saw her alive on August 8, 1930
and that death occurred, on the date stated above, at 11P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Hemorrhagic
Nephritis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Puerperium - Post -
Op. Caesarian
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? x
Did an operation precede death? Caesarian Date of Aug 3
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F B Dudley, M. D.
August 9, 1930 (Address) Caldwell, Ida

19. Place of Burial, Cremation, or Removal Jerome Ida
Date of Burial Aug 10-30 19

20. Undertaker Paul L.Case
Address Caldwell Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71372

RECEIVED AUG 12 1930

PLACE OF DEATH

County of Canyon

City of Caldwell Huston

Registration District No. 9

Primary Registration District No. 1005

Local Registrar's No. 92

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mae McCoy

(a) Residence. No. 1200 Block Albany St. St.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J W. McCoy.

6. DATE OF BIRTH (month, day and year) June 13-1910

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife +
(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Operator
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Lincoln Ragsdale

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Agnes Peters

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) Robert P. Landauer Albany St Caldwell Ida

15. Filed 8-6-1930 John H. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 3 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 7:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Head Crushed in
Auto accident
Coroners jury verdict

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8-5-30, 19.... (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Aug 5- 1930
20. Undertaker	Address
C. J. Peckham	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Dud

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71371

RECEIVED AUG 12 1930

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 90
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carolina Day

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Stephen O Day

6. DATE OF BIRTH (month, day and year): Feb. 6 - 1849

7. AGE: Years 81 | Months 5 | Days 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Isah Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina
12. MAIDEN NAME OF MOTHER: Mary P McKinney
13. BIRTHPLACE OF MOTHER (city or town) (State or County): North Carolina

14. Informant (Address): Mary E. Buell Wilder, Idaho

15. Filed 7-29- 1930 John L Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1925, to July 23, 1930, that I last saw her alive on July 23, 1930, and that death occurred, on the date stated above, at 05:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocardial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Nephritis

(duration) 2-5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Sam Hadley, M. D.
July 29, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Morris Hill — Date of Burial: July 30 1930
20. Undertaker: C. V. Peckham — Address: Caldwell, Idaho

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71375

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 89
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Harriet M. Beseecker.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John Beseecker.

6. DATE OF BIRTH (month, day and year): Jan. 19th 1878

7. AGE: Years 52 | Months 6. | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): East Annie New York

PARENTS

10. NAME OF FATHER: John Thomas.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Harriet M Pearson
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Canada.

14. Informant (Address): John Beseecker

15. Filed 7-25-, 1930 John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 20, 1930
that I last saw her alive on July 20, 1930
and that death occurred, on the date stated above, at 11 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W. M. Machell, M. D.
7/22, 1930 (Address) Parma, Ida.

19. Place of Burial, Cremation, or Removal: Rozwell — Date of Burial: July 22nd 1930
20. Undertaker: J. L. Foster — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 193

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7137G

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Canyon
City of Notus
Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 88
(No. Mem. Park Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4B

2. FULL NAME Mrs Harriet Benson

(a) Residence. No. R 1 Notus Ida St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter E.Benson

6. DATE OF BIRTH (month, day and year) 6-24 1889

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	--	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Athena Oregon
(State or country)

PARENTS

10. NAME OF FATHER Henry Molstron

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Finland

12. MAIDEN NAME OF MOTHER Margaret Tingman

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Norway

14. Informant Walter E.Benson
(Address) Notus Idaho R 1

15. Filed 7-21-, 1930. John S. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20-30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 20, 1930
that I last saw h[illegible] alive on July 20, 1930
and that death occurred, on the date stated above, at 12 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Chronic

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms
(Signed) [illegible], M. D.
7-21-, 19 (Address) Caldwell

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 7-22-30 19

20. Undertaker: Paul L.Case — Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71377

RECEIVED AUG 12 1930

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 87
(No. Caldwell Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME John Porter
(a) Residence. No. Wilder Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1841

7. AGE Years 89 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) J S Babcock Notus Idaho

15. Filed 7-21- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18-30, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1930 to July 18, 1930
that I last saw him alive on July 18, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Is remained [illegible] Date of 7/15/30
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) J. L. Case, M. D.
7/21, 1930 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery
Date of Burial: 7-21-30 19

20. Undertaker: Paul L. Case
Address: Caldwell Idaho

STATE OF IDAHO

RECEIVED AUG 12 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7137

County of Canyon

City of ~~Caldwell~~ Huston Registration District No. 3

Primary Registration District No. 2005 Local Registrar's No. 86

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Ray Eugene Williams

(a) Residence. No. R F D Huston Ida St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mch 14 1928

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	4	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Huston Ida
(State or country)

PARENTS

10. NAME OF FATHER H W Williams

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Nettie Warn

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Boise Idaho

14. Informant H W Williams
(Address) Huston Idaho

15. Filed 7-20-, 1930 John S. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18-30, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Drowning, Accidental.

Fell headfirst into barrel of water sunk in ground beside an irrigation ditch. No witnesses until the mother came from House and found him.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) No inquest.

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Paul L Case, M. D.
July 19-30 19..... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 7-20-30 19

20. Undertaker: Paul L.Case — Address: Caldwell Idaho

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 12 1930

DO NOT WRITE IN THIS SPACE
State File No. 71379

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 85
(No. 24)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dorothy Edna Hawkins

(a) Residence. No. Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 2 1921

7. AGE: Years 9 | Months 1 | Days 15 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER Clifford Hawkins
11. BIRTHPLACE OF FATHER (city or town) Wisconsin
(State or Country)
12. MAIDEN NAME OF MOTHER Edna Booth
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Illinois

14. Informant (Clifford Hawkins)
(Address) Riverside California

15. Filed 7/19, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 11-55 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Meningitis - spinal
& basal

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Culture

(Signed) W. M. Thompson M. D.
7/19, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 7/19 1930

20. Undertaker: O. V. Peckham — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71380

PLACE OF DEATH

County of Canyon
City of Middleton

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 84
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Sahishi Arakawa
(a) Residence. No. Whiffin Lane St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Japanese
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan.7 1870

7. AGE Years 60 Months 6 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railroad worker. and gardener.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER ~~Unknown~~ Arakawa
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Japan

14. Informant (Address) Paul L.Case Caldwell Idaho

15. Filed 7-14-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~July~~ June 14, 1930, to July 12, 1930
that I last saw him alive on July 12, 1930
and that death occurred, on the date stated above, at 9.00 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Brights Disease

~~(duration) yrs. mos. 28 ds.~~

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 28 ds.

18. Where was disease contracted if not at place of death? at Middleton Ida
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Analysis of urine
(Signed) J. W. Harker, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Middleton Cemetery
Date of Burial 7-14 1930

20. Undertaker Paul L.Case
Address Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED AUG 12 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71381

PLACE OF DEATH

County of Canyon

City of Notus

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 83

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Charles Henry Petersen.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 2 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	6	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ditch Rider.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho City
(State or country) Idaho

PARENTS

10. NAME OF FATHER C J F Petersen

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Catherine Degal

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Germany

14. Informant C.H.Petersen
(Address) Notus Idaho

15. Filed 7-14-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1930, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Sudden death from natural causes.
Died while alone at his regular work.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Paul L. Case, M. D.
July 14-30, 19..... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Parma Cemetery — Date of Burial: 7-14-30 19

20. Undertaker: Paul L.Case — Address: Caldwell Ida

Broadhurst

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71382

PLACE OF DEATH
County of Canyon
City of Notus

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 82
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miranda Jane Loyd
(a) Residence. No. Notus #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 28 1871

7. AGE Years 58 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER J. W. Dunaway
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Tenie Pendergraft
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tennessee

14. Informant (Address) Oscar Loyd Notus #1

15. Filed 7-12- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-18- 1930 to 3-15th 1930
that I last saw her alive on 3-15 1930
and that death occurred, on the date stated above, at 5-30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

Many years (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? Symptoms
(Signed) D. W. P. Broadhurst M.D.
7-11, 1930 (Address) Caldwell, Ida

19. Place of Burial, Cremation, or Removal Tuchelem Date of Burial 7/13 1930
20. Undertaker C. J. Peckham Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71383

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 81
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME James Woods
(a) Residence. No. 1023 Albany Caldwell, Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, ~~Married, Widowed, or Divorced~~ (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 14 1844
7. AGE Years 85 Months 10 Days 21 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R.R. Man - retired
(b) General nature of industry, business, or establishment in which employed (or employer) Construction
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Woodinten England

PARENTS
10. NAME OF FATHER James Woods
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane Ginn
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Will Evans - nephew 1023 Albany Caldwell

15. Filed 7-12- 1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 1930, to July 5, 1930
that I last saw him alive on July 4, 1930
and that death occurred, on the date stated above, at 8 - a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature] M.D.
7/4 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 7-8 1930
20. Undertaker C. W. Peckham
Address Caldwell Ida

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED AUG 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. State School + Colony St.)

File No. 71384

Registered No. 82

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold W. Cullen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 6 (Day) 1911 (Year)

7. AGE: 18 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Delia Simpkins

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [signature]

(Address) Nampa Idaho

15. Filed July 27 1930 Bertha Conway Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6th 1911, to July 23 1930 that I last saw him alive on July 23 1930 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(Duration) 2 Yrs. ..... mos. 2 ds.

Contributory (Secondary) Epilepsy

(Duration) 18 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Kootenai Co. Idaho

Former or usual residence Coeur d'Alene Idaho

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene, Idaho

DATE OF BURIAL: 21 1930

20. UNDERTAKER: [illegible]

ADDRESS: [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 12 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71385

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 51
1013

2. FULL NAME Gustave Edward Carter.

(a) Residence. No. Sheaville Ore. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1911-8-14

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	10	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER James V.A. Carter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming
12. MAIDEN NAME OF MOTHER Anna G. Heder.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant James V.A. Carter
(Address) Sheaville Ore.

15. Filed 7-2, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1930, to June 30, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
Double pneumonia

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Thrown from horse
injury to left chest (duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Jordan Valley Ore.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace E Belknap M. D.
July 1, 1930 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	7-2-30 19
20. Undertaker F. K. Robinson	Address Nampa Ida.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71386

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 86

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Charles Pitcher.

(a) Residence. No. 620-9ave.-S St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 7, 1849

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	10	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER Henry Pitcher

11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Wagner

13. BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country)

14. Informant Mrs Jenne Forgy
(Address) Nampa Ida.

15. Filed 7-1, 1930 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-18, 1930, to 6-29, 1930
that I last saw him alive on 6-28, 1930
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage with paralysis

..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W C. Wolter M. D.

6-30, 1930 (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	7-1-30 19
20. Undertaker	Address
F.K. Robinson	Nampa. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7138

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 106
Local Registrar's No. 87
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Robert Coyle

(a) Residence. No. 112 12" Ave North St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 30 1916

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Red Bluffs Calif
(State or country)

PARENTS

10. NAME OF FATHER Willis Coyle

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Oregon

12. MAIDEN NAME OF MOTHER Lena Goodwin

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Cincinnati O

14. Informant Mrs Willis Coyle
(Address) 112 12" Ave North Nampa Ida

15. Filed , 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Head and body crushed. Accidental
Fell from moving freight car in
front of wheels.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Paul L. Case M.D.
Coroner.
July 3-30, 19 Caldwell Ida

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cemetery — Date of Burial: 7-4-30 19

20. Undertaker: Paul L.Case — Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

PUBLIC HEALTH ADVISER
FOOD AND DRUG INSPECTION
BACTERIOLOGICAL LABORATORY
CHEMICAL LABORATORY
SANITARY ENGINEER
BUREAU OF CHILD HYGIENE
VITAL STATISTICS

DAVID BURRELL, COMMISSIONER

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BOISE, IDAHO

INSTITUTIONS
LAVA HOT SPRINGS, LAVA
IDAHO SOLDIERS' HOME, BOISE
NORTHERN IDAHO SANITARIUM,
OROFINO
STATE SCHOOL & COLONY, NAMPA

H. C. BALDRIDGE, GOVERNOR

71388

T.C. Horton
Nampa

Dear Doctor:

Idaho, as you no doubt are aware, is in the United States Death Registration Area and we are required to furnish transcripts of death certificates to the Census Bureau in Washington. In order to avoid delays in completing their statistics in Washington we are required to have these certificates as complete as possible in order to meet their requirements.

We are asking for some further information on the certificate mentioned below and enclose herewith a self-addressed penalty envelope for which no postage is required for your convenience in returning this letter with the information desired. Kindly co-operate by giving us this information as soon as possible so we will not be bothering you by writing again in reference to this certificate.

Respectfully yours,

C. K. Macey.

Special Agent, Bureau of Census.

In reference to the death certificate of:

James William Harlow who died at Nampa, Idaho on July 2, 1930
Cause of death given as "Septicemia."

Information DESIRED in order to complete certificate:

PLEASE STATE WHAT KIND OF AN OPERATION WAS THE PRIMARY CAUSE OF DEATH.

PLEASE ANSWER BELOW:

No operation was in any way the cause of death. Mr Harlow stepped on a nail which gave entrance to the infection. The wound was both opened, but that in no way contributed the his death,

T. C. Horton

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71385

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
(No. 515 - 15th Ave. No.)
Local Registrar's No. 88

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** James William Harlow

(a) Residence. No. 515 - 15th Ave. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15th 1915

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	0	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER H. J. Harlow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Edith Haggett.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon

14. Informant Mr. H. J. Harlow
(Address) Nampa, Idaho.

15. Filed 7-5, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2nd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30, 1930, to 7-2, 1930, that I last saw him alive on 7-2, 1930, and that death occurred, on the date stated above, at 5:15 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septicemia
Stepped on a nail
wound later opened (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~~Nampa~~ Emmett
Did an operation precede death? No Date of 6-30-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Hunter, M. D.
7-5, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 7-5-1930
20. Undertaker: Wm. D. Talley — Address: Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71389

PLACE OF DEATH
County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 89
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert B. Smith

(a) Residence. No. 2 miles no of Middleton St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Blanch Smith

6. DATE OF BIRTH (month, day and year) Feb 14 — 1880

7. AGE: Years 50 | Months 5 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Horace D. Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Mary Spurgeon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Lida Dunning
(Address) Glenns Ferry Idaho

15. Filed 7-10, 1930 Dexter Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27, 1929 to June 10, 1930
that I last saw h~~im~~ alive on June 10, 1930
and that death occurred, on the date stated above, at 9:00 AM m.
The CAUSE OF DEATH* was as follows:

Carcinoma bronchus left lung

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Aspiration sputum x ray + physical findings

(Signed) J. F. Hunt M.D.
7-10, 1930 (Address) Y 13 Eastman Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cem	7-5 1930
20. Undertaker	Address
Fred R Brinson	Nampa

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71390

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 98

44

2. FULL NAME James A. Fairley
(a) Residence. No. 219 - 14 - Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Frances Fairley

6. DATE OF BIRTH (month, day and year) July 7 1860

7. AGE: Years 69. Months 11. Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Prop. of Garage
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion, Iowa.

PARENTS
10. NAME OF FATHER Smith Fairley
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Frances Fairley
(Address) 219 - 14 Ave St Nampa.

15. Filed 7-3, 1930 Dexter Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930 to July 2, 1930
that I last saw him alive on July 2, 1930
and that death occurred, on the date stated above, at 9 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma involving the duodenum & head of pancreas
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)
Secondary nodules in liver (duration) ..... yrs. ? mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? autopsy findings
(Signed) H. P. Ross, M. D.
July 3, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fred K Robinson
Date of Burial: 7-3 1930

20. Undertaker: Kohlerlown Cem
Address: Nampa

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Ross

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED AUG 12 1930

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. State school + Colony St.)

File No. 71391

Registered No. 97

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Hinkleman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1919 (Year)

7. AGE: 10 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greencreek Idaho

10. NAME OF FATHER: Adolf Hinkleman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Helen Lohman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [signature]

(Address) Nampa Idaho

15. Filed 7-3 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1930 (Year) 1000

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to July 3 1930 that I last saw him alive on July 2 1930, and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Epilepsy

(Duration) since birth yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

..... 19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 18 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Greencreek Idaho

Former or usual residence: Greencreek Idaho

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Grangeville Ida

DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: F K Robinson

ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71392

PLACE OF DEATH

County of Canyon

City of Rural.

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 92

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME Eva Maud Fesler.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: W.E. Fesler.

6. DATE OF BIRTH (month, day and year): Aug. 26, 1874.

7. AGE: 55 Years, 6 Months, 27 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Kansas.

PARENTS

10. NAME OF FATHER: Newton Calhoun.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Duncan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: W.E. Fesler.
(Address) Nampa Ida.

15. Filed July 23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22, (Day) 1930, (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to July 22, 1930 that I last saw her alive on July 19, 1930 and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows: Acute intestinal obstruction.

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary): Carcinoma of the Sigmoid (duration) 2 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of June 5th 30.

Was there an autopsy? No.

What test confirmed diagnosis? Obstipation & distension

(Signed) Geo. D. A. Kellogg, M. D.

7/23/, 1930 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Star Cem.
Date of Burial: 7-22-30 19

20. Undertaker: F. K. Robinson
Address: Nampa Ida.

RECEIVED AUG 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7139 3

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1096
(No Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

2. FULL NAME Frances M. Ruse

(a) Residence. No. Christen Apartments St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 7 - 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs, or min.
75	10	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work City Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nevada

PARENTS

10. NAME OF FATHER F. M. Ruse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Ida Dryden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Mrs Minnie Ruse
(Address) Nampa Ida

15. Filed 7-27, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month), 26th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/18/, 1930, to 7/24/, 1930
that I last saw h[illegible] alive on July 26th, 1930
and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Complete suppression of urine following Splenectomy.
(duration) 0 yrs. 0 mos. 1 ds.
CONTRIBUTORY (Secondary) Nephritis and renal hemorrhages. (duration) 1 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes. Date of 7/24/30.
Was there an autopsy? No.
What test confirmed diagnosis? Catheterization
(Signed) Geo. D. A. Ruse g., M. D.
7/26/, 1930 (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlberg Cem	7-27 1930
20. Undertaker	Address
J. K. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71391

PLACE OF DEATH
County of Caribou
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2159
(No. Caribou Hospital)
Local Registrar's No. 21.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walderman Jensen Jr.

(a) Residence. No. ____ St. Moreland Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 18 1901

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	10		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Morgan
(State or country) Utah

PARENTS

10. NAME OF FATHER Walderman Jensen
11. BIRTHPLACE OF FATHER (city or town) Parowan
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Arletta Barney
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Utah

14. Informant Walderman Jensen
(Address)

15. Filed July 18, 1930 Dr. Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1936
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 18, 1936
that I last saw h[illegible] alive on July 18, 1936
and that death occurred, on the date stated above, at 12 noon m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? yes Date of 7/13/36
Was there an autopsy? 0
What test confirmed diagnosis? X-Ray
(Signed) Ellis Kackley, M. D.
19 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moreland Idaho — Date of Burial: July 21 1936
20. Undertaker: E J Peck — Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71395

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. 138 - North Normal St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. **FULL NAME** Baby Tolman

(a) Residence. No. 138 N. Normal St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6/18/30

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	0	0	8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Burley, Idaho.

PARENTS

10. NAME OF FATHER Don't-Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't-Know.

12. MAIDEN NAME OF MOTHER Gladys Tolman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Leola, Wis.

14. Informant (Address) Mrs. Channel.

15. Filed 7-11-, 1930 F. H. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ....., 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1930, to ....., 1930
that I last saw h..... alive on ....., 1930
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 1930 (Address) .....

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley, Cemetery	6/19/30

20. Undertaker	Address
Paul Beer	Twin Falls, Idaho.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71396

PLACE OF DEATH

County of .....

City of .....

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. 220-North Elba St.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John M. Chesley

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

101B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emily R. Chesley

6. DATE OF BIRTH (month, day and year) 1844

7. AGE 86 Years Months Don't Days Know If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Don't Know.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER Don't Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant (Address) Clellie M. Chesley Burley Idaho.

15. Filed 7-11-, 1930 F. H. Cutter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to June 22, 1930 that I last saw him alive on June 22, 1930 and that death occurred, on the date stated above, at 10:00 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Debility + Valvular incompetency

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. H. Cutter, M. D.

June 23, 1930 (Address) .....

19. Place of Burial, Cremation, or Removal Burley Cemetery — Date of Burial 19

20. Undertaker D. E. Johnson, P.B. — Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71398

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. 151 N. Miller St. Burley Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Isaac Gudmundsen
(a) Residence. No. 151 North Miller St. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Fanny Gudmundsen

6. DATE OF BIRTH (month, day and year) Mch 3 1861

7. AGE Years 69 Months 3 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Gudmundsen Gudmundsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iceland.
12. MAIDEN NAME OF MOTHER Marie Jacobsen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) Paul Gudmundsen

15. Filed 6-20-1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to June 3, 1930
that I last saw him alive on June 2, 1930
and that death occurred, on the date stated above, at 7:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy.

..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Ben Schultz M. D.
June 4, 1930 (Address) 144 S. Miller Burley Ida

19. Place of Burial, Cremation, or Removal Burley Cemetery
Date of Burial 6/6/30 19
20. Undertaker Paul Beer
Address
Licence E225

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71399

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. .....
(No. 130 - North Overland)
Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Hillhouse

(a) Residence. No. ..... American Falls. Idaho.
(Usual place of abode.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of David Hillhouse

6. DATE OF BIRTH (month, day and year) Oct 31 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Robert Ure
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Mary Muir
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant P. W. Hillhouse
(Address) American Falls Ida.

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to June 22, 1930, that I last saw her alive on June 19, 1930, and that death occurred, on the date stated above, at 2:40 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Sarcoma.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Debility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms.
(Signed) Dan Murphy, M. D.
June 23 1930 (Address) Burley Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Rockland, Idaho	
20. Undertaker D. E. Johnson By P.B.	Address Burley Idaho

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71409

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Rupert General Hospital, Rupert, Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Miller Durfee
(a) Residence. No. Almo, Idaho. St. 92
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Durfee

6. DATE OF BIRTH (month, day and year) Nov 7th 1867

7. AGE Years 62 Months 7 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Myron D. Durfee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Lerona E. Cahoon
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) Mrs. Louise D. Biefernich

15. Filed 6-20-, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 7, 1930
that I last saw him alive on June 6, 1930
and that death occurred, on the date stated above, at 4:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mesenteric Thrombosis

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? Yes Date of June 4-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Charles B. Beymer, M. D.
June 8, 1930 (Address) Oakley, Idaho

19. Place of Burial, Cremation, or Removal Almo Cemetery
Date of Burial June 10 1930

20. Undertaker Paul Beer
Address Twin Falls Idaho

(E 225)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71401

PLACE OF DEATH
County of Clearwater
City of Teakeau

CERTIFICATE OF DEATH
Registration District No. 90
Primary Registration District No. 2187 Local Registrar's No. 48
(No.) 101B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alta Mapes
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Mapes
6. DATE OF BIRTH (month, day and year) Aug 15, 1857
7. AGE: Years 72, Months 10, Days 3. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Monroe County Michigan

PARENTS
10. NAME OF FATHER ? Ostrander
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan (?)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) William Mapes Teakeau, Idaho
15. Filed 7/2, 1930. V. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 1, 1930
that I last saw her alive on July 1, 1930
and that death occurred, on the date stated above, at 12:45 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Terminal Pneumonia
(duration) yrs. mos. 40 hrs. ds.
CONTRIBUTORY (Secondary) Asthma since childhood
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. R. Robertson M. D.
7-2, 1930 (Address) Orofino Ida

19. Place of Burial, Cremation, or Removal: Teakeau
Date of Burial: July 3rd 1930
20. Undertaker: W. D. Pinson
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71402

PLACE OF DEATH
County of Clearwater
City of Pierce

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 49

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Otto Charles Ruehle

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Minnie C. Ruehle

6. DATE OF BIRTH (month, day and year) May 21, 1858

7. AGE: X Years 72 Months 1 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Plumber and tinsmith
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Milwaukee, Wis

PARENTS

10. NAME OF FATHER: August Ruehle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Berlin Germany
12. MAIDEN NAME OF MOTHER: Helena Erig
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Berlin Germany

14. Informant: Minnie C. Ruehle
(Address) Pierce, Ida.

15. Filed 7/5, 19.. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 19.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 3, 1930
that I last saw him alive on ..... 19..
and that death occurred, on the date stated above, at 8:45 A m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) several yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A. B. Pappenhagen, M. D.
July 4, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pierce Ida — Date of Burial: 7/6 19..

20. Undertaker: W. A. Shaw — Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71403

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 50

92

2. FULL NAME Elizabeth Carr

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvanus Carr

6. DATE OF BIRTH (month, day and year) Sept 26 1870

7. AGE Years 59 Months 8 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Randolph Co West Va

PARENTS
10. NAME OF FATHER Joseph L White
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va.
12. MAIDEN NAME OF MOTHER Susan E Helmick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Va.

14. Informant Ord Car
(Address)

15. Filed 7/7, 19.... [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 — 2 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to 7 — 2, 1930
that I last saw her alive on 7 — 2 —, 1930
and that death occurred, on the date stated above, at 6:45 a m.
The CAUSE OF DEATH* was as follows:
Probably Embolism
few minutes (1/2 hr)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) High B.P. Gall stone
colic (duration) years ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms —
(Signed) [signature], M. D.
7/5, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Orofino Ida
Date of Burial 7/6 19

20. Undertaker W. D. Pinson
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71401

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2177

Local Registrar's No. 51

(No. 117)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nestor Hill

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) Finn
(State or country)

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) —
(State or Country)

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed 7/12, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27, 1930, to July 12, 1930
that I last saw him alive on July 11, 1930
and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:
appendicitis - suppurative
(duration) — yrs. — mos. 12 ds.
CONTRIBUTORY (Secondary) Intestinal Obstruction
(duration) — yrs. — mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 7-1930
Was there an autopsy? yes partial
What test confirmed diagnosis? no
(Signed) A.B. - Pappenhagen, M. D.
July 12, 1930 (Address) orofino. -

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Idaho	7/14 19
20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71405

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2177

Local Registrar's No. 52

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

748

2. FULL NAME George McCoy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9. BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) —

14. Informant Tom Walker
(Address) Orofino

15. Filed 7/21, 19..... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 20, 1930
that I last saw h— alive on July 20, 1930
and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None.

(Signed) R. J. Hopkins M. D.
7/21/30, 19..... (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	7/22 19
20. Undertaker W. A. Shaw	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71406

PLACE OF DEATH
County of Elegiuatu
City of Orifina

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

74A

2. FULL NAME Oline C. Johnson
(a) Residence. No. ..... St. Coeur d'Alene, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Axel W. Johnson

6. DATE OF BIRTH (month, day and year) 1876 – 12-23

7. AGE Years 53 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER — Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Marie Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant A W Johnson
(Address) Stanley Hill Cd'Alene

15. Filed 7/26, 19.. U A Shaw Ida. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 22, 1929, to July 25, 1930
that I last saw her alive on July 25 1930
and that death occurred, on the date stated above, at 3.45 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage (apoplexy)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Psychosis with cerebral arteriosclerosis (duration) 3 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Physical signs.
(Signed) John Irvine McKelvey M. D.
July 25 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Coeur d'Alene
Date of Burial 7-28 1930

20. Undertaker Cassedy Funeral Home
Address Coeur d'Alene Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71407

PLACE OF DEATH

County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 9157

Local Registrar's No. 54

(No. 1660)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ward Pack

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 5 1915

7. AGE	Years	Months	Days	If LESS than 1 day,
	15			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida

PARENTS

10. NAME OF FATHER Ed Pack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER A Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. Pack
(Address) Orofino

15. Filed 7/31, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 4:55 P m.
The CAUSE OF DEATH* was as follows:

Accidental Killed when train
Left track Breaking his neck.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, ~~M. D.~~
8/1, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	8/3 19
20. Undertaker	**Address**
W. A. Shaw	Orofino

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71405

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Elmore

City of MT. Home. Idaho.

Registration District No. 34

Primary Registration District No. 2020

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1946 C

2. FULL NAME Elmer Edwin Harder

(a) Residence. No. Glenns Ferry, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Harder

6. DATE OF BIRTH (month, day and year) 4/22/1905.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	2	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Constuction
(c) Name of employer Geo. W. Winegar.

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER J.J.Harder

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Caroline M. Heath

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) J.J.Harder Glenns Ferry, Idaho.

15. Filed July 21, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 19th 1930
(Month) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw him alive on , 19

and that death occurred, on the date stated above, at About 6.p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Auto accident, with no other car involved.

Accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G.S. Zacher Coroner Elmore Co., M. D.

7/20/30, 19 (Address) Mt. Home, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry, Idaho.	7/21/30 19

20. Undertaker G.C.Zacher. Address Mt. Home, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71409

PLACE OF DEATH
County of Elmore
City of Mt. Home, Idaho.

Registration District No. 34
Primary Registration District No. 2020
Local Registrar's No. 10
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Leona Stevens
(a) Residence. No. Mt. Home, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas Alvin Stevens deceased

6. DATE OF BIRTH (month, day and year) July 2, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Abraham Carns

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Ann Armstrong

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Pearl S. Barber Mt. Home Ida.

15. Filed July 24, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Natural Death
Found Dead In Bed. No one Present at Time of death
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Heart Trouble, Anemia.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Elmore Co.
What test confirmed diagnosis?
(Signed) J. S. Barber Coroner, M. D.
7/23, 1930 (Address) Mt. Home, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho.	7/25 1930
20. Undertaker J. S. Barber	Address Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71410

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Elmore
City of Mt. Home, Idaho.

Registration District No. 34
Primary Registration District No. 2020
Local Registrar's No. 11
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1944

2. **FULL NAME** Theodore Adwin Montague

(a) Residence. No. Glenns Ferry, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha Lamoreaux Montague

6. DATE OF BIRTH (month, day and year) 5-14-30

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER John Theodore Montague

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Mariam McCall

13. BIRTHPLACE OF MOTHER (city or town) (State or County) N.Y.

14. Informant (Address) J.D. Montague MT. Home, Idaho.

15. Filed July 30, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 30, 1930, that I last saw him alive on July 30, 1930, and that death occurred, on the date stated above, at 3.40 Am.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Heat stroke -

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - and High blood pressure (duration) 2 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Glenns Ferry Ida
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?

(Signed) O. P. Hamilton M. D.
July 30, 1930 (Address) Mtn. Home, Idaho

19. Place of Burial, Cremation, or Removal: Preston, Idaho. Date of Burial: 8-2-1930
20. Undertaker: G. S. Zarker Address: Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71411

DO NOT WRITE IN THIS SPACE
State File No. ~~71350~~

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 299

131

2. FULL NAME Margaret Jane Gray
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Clinton Gray

6. DATE OF BIRTH (month, day and year) Apr. 17, 1860

7. AGE Years 70 Months 2 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Seco - Illinois

PARENTS
10. NAME OF FATHER David Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Anna Sugardaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant C C Gray
(Address) Stites

15. Filed June 30, 1930 J M Verbeekmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28 1930
~~April~~ ~~17th~~ ~~1860~~
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 28 1930
that I last saw h SW alive on June 28, 1930
and that death occurred, on the date stated above, at 3 45 p m.
The CAUSE OF DEATH* was as follows:
Acute on a chronic Bright
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Convulsion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Albumin
(Signed) H W Wentworth, M. D.
June 30, 1930 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Stites
Date of Burial June 30 1930

20. Undertaker Trenary
Address Kooskia

Jmc 6 pm.

RECEIVED AUG 14 1930

71412

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71256~~

PLACE OF DEATH
County of Jerome.
City of Eden.

Registration District No. 37
Primary Registration District No. 2085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

Lamb
65-B

2. FULL NAME Kathleen Virginia Snyder
(a) Residence. No. Eden, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan. 15 1925
7. AGE Years 5 Months 6 Days 11 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Washington
PARENTS
10. NAME OF FATHER Richard Snyder.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oklahoma
12. MAIDEN NAME OF MOTHER Annabelle Whittaker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri
14. Informant Mrs Kathryn Westhook
(Address) Boise, Idaho
15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 26 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 6, 1930, to July 26, 1930
that I last saw him alive on July 26, 1930
and that death occurred, on the date stated above, at 2:40 P. m.
The CAUSE OF DEATH was as follows:
Hodgkins disease
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical and Laboratory
(Signed) H. E. Lamb, M. D.
7-28, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery
Date of Burial 7/28/30
20. Undertaker F. E. Drake
Address Twin Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

7141

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7157

PLACE OF DEATH Jerome
County of Twin Falls
City of Eden Ida
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No.
(No. Eden Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

133

2. FULL NAME Paul Andrew Craig

(a) Residence. No. Eden Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 21 1930

7. AGE: Years | Months | Days: 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Eden

PARENTS

10. NAME OF FATHER: Leonard C Craig
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denver Colo
12. MAIDEN NAME OF MOTHER: Marguerite Kinalow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Leonard C Craig
(Address): Eden Ida

15. Filed August 6 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21- 1930, to July 28 1930
that I last saw him alive on July 28 1930
and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy

(Signed) H N Leete, M. D.
7-29- 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: P J Grossman 7-29 1930

20. Undertaker — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71414

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71258~~

PLACE OF DEATH

County of Jerome

City of

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Allen Gifford

170

(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Annie Gifford

6. DATE OF BIRTH (month, day and year)

7. AGE: 41 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Geo. W Gifford

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louisa Hale

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Geo. W Gifford
(Address) Utah

15. Filed 8/2, 1930 Chas F Zeller Registrar
Dmc

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1930, to Aug. 1, 1930

that I last saw h alive on Aug. 1st, 1930

and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Gun Shot wound of head, self inflicted

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. F. Zeller M. D.

8/2, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls | Date of Burial 19

20. Undertaker: D R L Harrison | Address: Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 6 1930

71415

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71259~~

PLACE OF DEATH

County of Jerome

City of Jerome

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mrs Annie Speakman

(a) Residence. No. Jerome St. Sr. Schmerchal

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1 / 1854

7. AGE 75 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Wilson Speakman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn

12. MAIDEN NAME OF MOTHER Eliza Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Bertha S. Fairman

(Address) Jerome

15. Filed 7/19, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1930 4-15

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1930, to June 11, 1930

that I last saw her alive on June 11, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

apoplexy (duration) 2 yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm F Schmerschall M. D.

June 14, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial

Jerome Cemetry June 15 1930

20. Undertaker Address

T C Drake Sun Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71416

DO NOT WRITE IN THIS SPACE
State File No. ~~71260~~

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 112

74a

2. FULL NAME Otilia B. Satchwell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest R. Satchwell

6. DATE OF BIRTH (month, day and year) October 15, 1866

7. AGE Years 64 Months 9 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Do not know Otto!

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Do not know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant ✓
(Address) Walter R. Satchwell

15. Filed 7-29, 1930 Post Falls Ida H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1, 1927 to July 14, 1930
that I last saw her alive on July 13, 1930
and that death occurred, on the date stated above, at 4:00 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) 2 yrs. 9 mos. ..... ds.
CONTRIBUTORY (Secondary) Hemiplegia
..... (duration) 2 yrs. 9 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Frank Weiss M. D.
7/16, 1930 (Address) Rathdrum Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pine Grove Cemetery - Rathdrum
Date of Burial 7/17 1930

20. Undertaker Cassely Funeral Home
Address Rathdrum

71417

Form V. S. No. 5 20M-1-16-12 REC'D AUG 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 30

County of

Primary Registration District No. 1050.

File No. 11 ~~71201~~

City of

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosina F. Jerman

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Nov. 26 - 1842 (Month) (Day) (Year)

7. AGE: 87 yrs. 8 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired House wife
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Junius R. Newsom

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Gibbs

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs D. H. Smith

(Address) Post Falls Ida

15.

Filed 7-29 1930 H. J. Sturges Local Registrar

MEDICAL CERTIFICATE OF DEATH.

49

16. DATE OF DEATH: July (Month) 26th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1930 to July 26 1930 that I last saw her alive on July 26 1930 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Heart Disease (Angina Pectoris)

(Duration) yrs. mos. ds.

Contributory (Secondary) acute ~~Indigestion~~ Indigestion

(Duration) yrs. mos. 10 ds.

(Signed) T. L. McCauley M. D.

1930 (Address) Post Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn

DATE OF BURIAL: 7-29 1930

20. UNDERTAKER: Smith & Co.

ADDRESS: Spokane Wn

ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71418

DO NOT WRITE IN THIS SPACE

State File No. 21262

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 110

PLACE OF DEATH

County of Kootenai

City of Rathdrum

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oscar Free 90

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Lilly Belle Free

6. DATE OF BIRTH (month, day and year) -5-28

7. AGE

Years	Months	Days	If LESS than 1 day,
82	1	29	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Geo. Free

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know Ind.

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) " " (State or Country)

14. Informant J E Free
(Address)

15. Filed 7-29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 27, 1930
that I last saw h alive on July 26. 1930
and that death occurred, on the date stated above, at 6. 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy - Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Stern, M. D.

7/28. 1930 (Address) Rathdrum, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pleasant View Pleasant View Cem. | Date of Burial 7-30 1930

20. Undertaker Cassidy Funeral Home | Address Rathdrum

71419

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71263~~

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

119

2. FULL NAME Alonzo Peck.
(a) Residence. No. Bayview Ida. ~~St.~~
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Martha Peck
6. DATE OF BIRTH (month, day and year) 1879 - 1 - 2
7. AGE Years 51 Months 6 Days 18 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS
10. NAME OF FATHER Alfred Peck.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know think Ont.
12. MAIDEN NAME OF MOTHER Mary Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know.

14. Informant Wesley V. Peck
(Address) Bayview. Ida.

15. Filed 7-29-, 1930. H. J. Sturges. M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 1930 to July 20, 1930
that I last saw him alive on July 20, 1930
and that death occurred, on the date stated above, at 9 P.m.
The CAUSE OF DEATH was as follows:
Peritonitis General - Following ruptured sigmoidal ulcer.
..... (duration) ..... yrs. ..... mos. 6½ ds.
CONTRIBUTORY (Secondary) Sigmoidal Ulcers
..... (duration) 6 yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Tropics?
Did an operation precede death? yes Date of July 14
Was there an autopsy? No Cloud ulcer opening
What test confirmed diagnosis? Clinical Signs
(Signed) E L Spohn M. D.
July 22 1930 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Evergreen Cem Kathdrum — Date of Burial 7-22 1930
20. Undertaker Coeur d'Alene Ida — Address C D Alene.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71420

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71264~~

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 108

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No.) HH
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas. W. Horsington

(a) Residence. No. 91 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Bessie Horsington

6. DATE OF BIRTH (month, day and year) 1850-3-16

7. AGE	Years	Months	Days	If LESS than 1 day,
	80	4	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Scaler + grader
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orleans Co. N.Y. State

PARENTS
10. NAME OF FATHER Edwin Horsington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Margette Brooks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y. State

14. Informant Bessie Horsington
(Address)

15. Filed 7-28-, 1930 H.J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930 to July 23, 1930
that I last saw h~~i~~m alive on July 23 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) H.J. Sturges M. D.
July 25, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'D'Alene	7-27 1930
20. Undertaker	Address
Casey Funeral Home	C'D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71421

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71265~~

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 109

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

198 E

2. FULL NAME Alexander Bee

(a) Residence. No. 1100 - Davidson St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Anna Bee

6. DATE OF BIRTH (month, day and year) 1846 - 7 - 13

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	0	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cattle buyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Glascow Scotland

PARENTS

10. NAME OF FATHER W - Bee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs H.M. Hansen

(Address) 1100 W. Davidson Ave.

15. Filed 7-28-, 1930 W J Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to July 25, 1930

that I last saw him alive on July 25, 1930

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Shock- following automobile accident.

(duration) ....yrs. ....mos. one ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) ....yrs. ....mos. one ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harold T. Anderson, M. D.

July 28, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C d'Alene	7-25 1930
20. Undertaker Cassedy Funeral Home	Address C d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71422

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71266~~

PLACE OF DEATH

County of Kootenai

City of Near Grand Jc.

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 102

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Micheal T. Bradley

(a) Residence. No. ..... St. Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 0 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Bradley

6. DATE OF BIRTH (month, day and year): Sept. 24, 1869

7. AGE: 60 Years, 9 Months, 28 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Road Master

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: Northern Pacific R. R.

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: Thomas Bradley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unobtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: John S. Bradley
(Address) 2709 W Broadway, Spokane, Wn.

15. Filed 7/17, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: accidental. Skull Crushed thrown from Rail Road speeder. Northern Pacific R.R. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) R. B. Mooney Brown, ~~M. D.~~

July 15, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place ~~of Burial, Cremation, or~~ Removal: Spokane Wn.

Date of Burial: July 19, '30

20. Undertaker: Hennessey & Calloway

Address: Spokane Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71423

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [redacted]

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 20
Primary Registration District No. 1050
Local Registrar's No. 106
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Jacobson
(a) Residence. No. 99 4th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1910 4-27

7. AGE	Years	Months	Days	If LESS than 1 day,
	20	2	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Employed at-
(b) General nature of industry, business, or establishment in which employed (or employer): Bx factory
(c) Name of employer: J. W. Cook.

9. BIRTHPLACE (city or town) (State or country): Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER: Mathew Jacobson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Austria-Hungaria
12. MAIDEN NAME OF MOTHER: Julia Kola Kofski.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria-Hungaria.

14. Informant: Mrs M. E. Asplund
(Address)

15. Filed 7-29-, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 19, 1930, that I last saw her alive on July 19, 1930, and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Abortion, self-induced (July 8, 1930) (duration) yrs. mos. 11 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Harold T. Anderson M. D.
July 21, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem. CdAlene	7- 1930

20. Undertaker	Address
Cassidy Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71421

DO NOT WRITE IN THIS SPACE

State File No. ~~71268~~

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 105

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME Mary Ahlborn

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 7 17

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, 14 hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER John F. Ahlborn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Jane Henry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant John Fred Ahlborn
(Address) Bonners Ferry Idaho

15. Filed 7-29-, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 17, 1930
that I last saw her alive on July 17, 1930
and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:
Atelectasis.

..... (duration) ..... yrs. ..... mos. 1 ds

CONTRIBUTORY (Secondary) Breech presentation.

..... (duration) ..... yrs. ..... mos. 1 ds

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John C. Wood M. D.

July 19, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 7-19 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7425 ~~11269~~

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 104
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm E. Williams

(a) Residence. No. 1402 - N. 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1929 - 4 - 25

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	2	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minot N. D.

PARENTS

10. NAME OF FATHER Wm E. Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Rose Benson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Forest City, Iowa

14. Informant Wm E. Williams
(Address)

15. Filed 7 - 29, 1930 L. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-19, 1930, to 7-19, 1930
that I last saw her alive on ....., 19....
and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:
Ran over by automobile
death was instantaneous

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) E. H. Teed M. D.
7-21-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest City Mt. Vernon Cem. Ark.	7 - 1930
20. Undertaker	Address
Conrad Funeral Home	Coeur d'Alene Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71426

RECEIVED AUG 11 1930

PLACE OF DEATH

County of Kootenai

~~City of~~ Hayden Lake

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. ~~71270~~

Local Registrar's No. 103

182

2. FULL NAME George L. Huber

(a) Residence. No. ..... St. Kellogg Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. —yrs. —mos. —ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19 - 1907

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	1	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Ida.

PARENTS

10. NAME OF FATHER Henry U Huber

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rock Island Mich

12. MAIDEN NAME OF MOTHER Hazel Losie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario Canada

14. Informant Henry U Huber
(Address) Kellogg Ida.

15. Filed July 21, 1930. H. J. Sturges. M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 20 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 545 P. m.

The CAUSE OF DEATH* was as follows:

accidental drowning at Honeysuckle beach at Hayden Lake, Idaho.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Best M. D.

7-21, 1930 (Address) Coeur d'Alene Justice of the Peace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida

Date of Burial 19

20. Undertaker R B. Mooney DDK

Address Coeur d'Alene Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71427

DO NOT WRITE IN THIS SPACE
State File No. ~~71271~~

PLACE OF DEATH
County of Kootenai
City of Dalton Gardens

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 100

2. FULL NAME Calvin Eugene Conner. 100a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Conner.

6. DATE OF BIRTH (month, day and year) 12-24-

7. AGE Years 74 Months 6 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio. Richard Conner.

12. MAIDEN NAME OF MOTHER Cynthia Ferguson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Martha M. Conner.
(Address)

15. Filed 7-16-, 1930 Harold James Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to July 14, 1930
that I last saw him alive on July 14, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia.

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Supra pubic prostatectomy.

..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of June 8. 30
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) John Wood, M. D.
July 16, 1930 (Address) Coeur d'Alene. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal C D'Alene Id. Forest Cem. Date of Burial July-16 1930

20. Undertaker Cassedy Funeral Home. Address C D'Alene.

RECEIVED AUG 11 1930

71428

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71270~~

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 97

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Leonard H. Patchen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Emma L. Patchen

6. DATE OF BIRTH (month, day and year) 1844 - 5 - 19

7. AGE Years 86 Months 1 Days 24 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Galway, Saratoga Co N. Y.

PARENTS
10. NAME OF FATHER Hiram H. Patchen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Harriet Degoley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Mrs Emma L. C. Patchen
(Address)

15. Filed 7-16-, 1930 H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 13, 1930
that I last saw him alive on July 13, 1930
and that death occurred, on the date stated above, at 12 M m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
..... (duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senility.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Usual.
(Signed) John O'Wood, M. D.
July 16, 1930 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C. d'Alene | Date of Burial 7-16 1930

20. Undertaker Cassidy Funeral Hm | Address C. d'Alene

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71429

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 98

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Evelyn Mudge

(a) Residence. No. / St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1930 - 7 - 13

7. AGE Years	Months	Days	If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Idaho

PARENTS

10. NAME OF FATHER Clinton Mudge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Coeur d'Alene Idaho
12. MAIDEN NAME OF MOTHER Ruth Browne
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S.

14. Informant Clinton C Mudge
(Address)

15. Filed 7-16-, 1930 Harold J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ...m.
The CAUSE OF DEATH* was as follows Premature birth

(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Exam.
(Signed) Harold J Sturges M. D.
7-14, 1930 (Address) Cda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem.	7-14 1930
20. Undertaker	Address
Cassidy Funeral Home	Cda.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 11 1930

71430

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1274

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 97

PLACE OF DEATH
County of Kootenai
City of Gibbs
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl A. Barker

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1872 - 9 - 29

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	10	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tiler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Winton Lbr. Co

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Thyra LeBert
(Address)

15. Filed 7-16-, 1930 Harold J. Sturges, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930 to July 11, 1930
that I last saw h[illegible] alive on July 11, 1930
and that death occurred, on the date stated above, at 10-00 A.M.
The CAUSE OF DEATH* was as follows: Myocarditis Acute

(duration) yrs. mos. 4 days
CONTRIBUTORY (Secondary) Bronchial Asthma
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? At home - Gibbs.
Did an operation precede death? [illegible] Date of July 10, 1930
Was there an autopsy? No. Clinical signs
What test confirmed diagnosis?
(Signed) E R Sponenberg, M. D.
July 12, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	7-13 1930
20. Undertaker	Address
Cassedy Funeral Home	CdAlene.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71431

Registration District No. 30

Primary Registration District No. 1850

Local Registrar's No. 96

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Margarethea C. D. Dose

(a) Residence. No. Coeur d'Alene Home for the Aged St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

74A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm Dose.

6. DATE OF BIRTH (month, day and year) 1851 - 8 - 3

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	10	29	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) New York City N-Y
(State or country)

PARENTS

10. NAME OF FATHER Christopher Bellmar

11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth —

13. BIRTHPLACE OF MOTHER (city or town) Germany.
(State or Country)

14. Informant C. F. Johnson

(Address) Coeur d'Alene Homes Coeur d'Alene

15. Filed 7-16-, 1930 H. J. Sturges - M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to June 24, 1930

that I last saw her alive on June 24, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, right.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

unknown (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Hazel T. Cruteson M. D.

July 5, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	7-6 1930

20. Undertaker	Address
Casady Funeral Home	Cd'A

RECEIVED AUG 11 1931

71432

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71276~~

PLACE OF DEATH
County of Koot.
City of C.D.A.

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

148e

2. FULL NAME Everett E. Holley.

(a) Residence. No. Lane Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. — yrs. 6 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Opal Holley

6. DATE OF BIRTH (month, day and year) June 19, 1894

7. AGE Years 36 Months 0 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Western Pine Mfg. Co.

9. BIRTHPLACE (city or town) (State or country) Seattle Wn.

PARENTS
10. NAME OF FATHER John Holley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Louise Moore.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs. Opal Holley
(Address) Lane Idaho

15. Filed 7-16-, 1930. Harold J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 8, 1930
that I last saw him alive on July 8, 1930
and that death occurred, on the date stated above, at 4 P.m.
The CAUSE OF DEATH* was as follows:
Fracture of skull-basal due to auto accident
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Harold J. Sturges M. D.
7-10, 1930 (Address) CDA Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wn. Date of Burial July 11 1930

20. Undertaker R.B. Mooney Address C.D.A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 11 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE

State File No. 7133

Local Registrar's No. 94

(No. 428)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie May Tosspon.

(a) Residence. No. [illegible] St. Fanwood Ida.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alvin Chas Tosspon.

6. DATE OF BIRTH (month, day and year) Feb. 13 - 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	4	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Council Bluffs Iowa.

PARENTS

10. NAME OF FATHER Wm J. Randall.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York - State -

12. MAIDEN NAME OF MOTHER Charlette Coy.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York State

14. Informant Alvin Chas Tosspon

(Address)

15. Filed 9-16, 1930 W J Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 5 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harold T Anderson, M. D.

July 7, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairmount Cem Spokane Wash	7-9 1930

20. Undertaker Smith & Co Address Spokane Wash.

71434

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21225

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1020
(No. Lake Side Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 93

112

2. FULL NAME Albert A. Campbell

(a) Residence. No. 401 Reed St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Inez M. Campbell

6. DATE OF BIRTH (month, day and year) Feb. 3, 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	4	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Geo Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Jersey
12. MAIDEN NAME OF MOTHER Lydia ---
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs. Inez M. Campbell
(Address)

15. Filed 7-16-, 1930. H. J. Sturges M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 2, 1930
that I last saw h[illegible] alive on July 2, 1930
and that death occurred, on the date stated above, at 2.50 P.m.
The CAUSE OF DEATH* was as follows:
Acute Hemorrhage (gastric)
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Gastric Ulcer
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at his Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) [illegible] M. D.
July 3, 1930 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	July 5 1930
20. Undertaker	Address
C. B. Mooney	Coeur d Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71435

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71279~~

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. Lakeside Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

149

2. FULL NAME Millie Wang
(a) Residence. No. 1004 - 4th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Ludvig Wang

6. DATE OF BIRTH (month, day and year) 1890 - 7 - 27

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
39	11	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cooperstown N. D.

PARENTS

10. NAME OF FATHER Christ Overby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Martha Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Ludvig Wang
(Address) Coeur d'Alene Idaho

15. Filed 7-16-, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1930, to July, 1930
that I last saw her alive on July 6, 1930
and that death occurred, on the date stated above, at 11:45 P.m.
The CAUSE OF DEATH* was as follows:
Difficult & prolonged labor
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ch. Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes no Date of 7-6-30
Was there an autopsy?
What test confirmed diagnosis? Exam
(Signed) Harold J. Sturges M. D.
7-7, 1930 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Conrad Cem. Kalispell Mont. Date of Burial 7-9 1930

20. Undertaker Cossedy Funeral Home Address Coeur d'Alene Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71437

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71281~~

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 90

188a

2. FULL NAME Sidney L. R. Farnsworth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Farnsworth

6. DATE OF BIRTH (month, day and year) February 17, 1847.

7. AGE Years 83 Months 3 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired - Grain Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington N. Hampshire

PARENTS
10. NAME OF FATHER Joe Farnsworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Hampshire?
12. MAIDEN NAME OF MOTHER Mary Fairbanks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Do not know

14. Informant O. G. Farnsworth
(Address) Rathdrum Idaho

15. Filed 7-31-, 1930 H. J. Sturges. MD. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5:40 P m.
The CAUSE OF DEATH* was as follows:
Accident. Passenger train #3 N. P. Rwy. struck him at a crossing, broke his neck, left leg & arm broken, almost every bone in his body broken. (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) — sudden death. I saw & examined deceased right after accident. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Frank Wenz, M. D.
6/16, 1930 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery - Coeur d'Alene
Date of Burial: 6/17 1930

20. Undertaker: Cassely Funeral Home
Address: Rathdrum

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71438

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7288

PLACE OF DEATH

County of Kootenai
City of Rathdrum
Registration District No. 30
Primary Registration District No. 1050
(No. Kootenai County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 89

74A

2. FULL NAME Enos, Erickson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of [illegible] 1853

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
77			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant G. B. Nelson
(Address) Rathdrum

15. Filed 7-31-30, 1930 W. J. Sturges, MD
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 10, 1930
that I last saw him alive on June 10, 1930
and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Frank Wann, M. D.
6/16, 1930. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery	6-12 1930

20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71439

RECEIVED AUG 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71283~~

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88

101a

2. FULL NAME Mary Gertrude Woolery
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 27 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of S. B. Woolery
6. DATE OF BIRTH (month, day and year) Jan. 31 - 1859
7. AGE Years 71 Months 4 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER George Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Gertrude —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant S B Woolery
(Address) Rathdrum Idaho

15. Filed 7-31-, 1930. H. J. Sturges. M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 9, 1930
that I last saw her alive on June 9, 1930
and that death occurred, on the date stated above, at 6.20 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
about 2 (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Frank Wenz, M. D.
6/10, 1930 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pine Grove Cemetery Rathdrum
Date of Burial 6/11 1930
20. Undertaker Carsedy Funeral Home
Address Rathdrum

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. [illegible] RECEIVED AUG 11 1930

71440

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62

Primary Registration District No. 2142

(No. ....., ... St.)

File No. ~~71281~~

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira D. J. Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 20 (Day) 877 (Year)

7. AGE: 52 Yrs. 11 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Genesee Idaho

10. NAME OF FATHER: Jas Henson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Luedke

(Address) Genesee, Idaho

15. Filed July 22 1930 W H Ehlen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1930 (Year) 90

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19..., that I last saw him alive on ..... 19..., and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows: Died before my arrival Heart disease of some kind.

..... (Duration) ..... Yrs. — mos. — ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Ehlen M. D.

7/22 1930 (Address) Genesee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee, Idaho

DATE OF BURIAL: 7/22 1930

20. UNDERTAKER: Brower-Wann Co

ADDRESS: Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M. 1-19 RECEIVED AUG 11 1930

71441

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Latah

City of Genesee Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62

Primary Registration District No. 2142

(No. ..... St.)

File No. ~~71285~~

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. Mochel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1867 (Year)

7. AGE: 63 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: George L. Mochel

11. BIRTHPLACE OF FATHER (State or Country): Alsace Lorraine

12. MAIDEN NAME OF MOTHER: Elizabeth Lenertz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leonard E. Mochel

(Address) Lewiston Ida

15. Filed July 6 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

48a

16. DATE OF DEATH: July (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1930, to July 4 1930, that I last saw him alive on July 4 1930, and that death occurred on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary): Mytral Insufficiency

(Duration) 2 yrs. — mos. — ds.

(Signed) Walter A. Berg M. D.

July 8 1930 (Address) Uniontown Wa.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee Ida

DATE OF BURIAL: 7/7 1930

20. UNDERTAKER: Brown Wain Co.

ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 11 1930

71442

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Genesee

Registration District No. 62

Primary Registration District No. 2142

(No. ....., ... St.)

File No. ~~71286~~

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Holly Frederick Trimmer

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: Jan 17, 1874 (Month) (Day) (Year)

7. AGE: 56 yrs. 6 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sane County, Oregon

10. NAME OF FATHER: William Trimmer

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Ellen Vaughn Myers

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anna Trimmer
Mrs. Anna Trimmer

(Address) Genesee

15. Filed 8-30-30 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

105

16. DATE OF DEATH: July 31, 1930 (Month) (Day) (Year) 191...

17. I HEREBY CERTIFY, That I attended deceased from July 15 1930 to July 31 1930 that I last saw him alive on July 31 1930 and that death occurred on the date stated above, at 1 00 M.

The CAUSE OF DEATH* was as follows:

Asthma

..... (Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) Acute Cardiac Decompensation

..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Walter A. Burg M. D.

8/1 1930 (Address) Uniontown

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee

DATE OF BURIAL: 8/3/30 191...

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 16 1930

71443

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71287~~

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

90

2. FULL NAME James Henry Whiteaker
(a) Residence. No. Salmon Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Fisher Whiteaker

6. DATE OF BIRTH (month, day and year)

7. AGE 67 Years | Months 1 | Days 16 | If LESS than 1 day 23 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter and Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lane County Oregon

PARENTS
10. NAME OF FATHER John Whiteaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant J. C. Whiteaker
(Address) 2810 Eastlake ave Seattle Wn

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16" (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10", 1930, to July 16", 1930
that I last saw him alive on July 16, 1930
and that death occurred, on the date stated above, at 11.05 P. m.
The CAUSE OF DEATH* was as follows: Valvular Heart disease (Decompensated one month)
(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) A. Stratton M. D.
7/17, 1930 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Eugene Oregon | Date of Burial 19

20. Undertaker: Wm. C. Doebler | Address: Salmon

71444

RECEIVED AUG 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11285

PLACE OF DEATH

County of ....

City of ....

Registration District No. ....

Primary Registration District No. ....

(No. ....)

Local Registrar's No. ....

(If death occurred in a hospital or institution, give its name instead of street and number.)

114

2. FULL NAME Charles Washington Cockrell

(a) Residence. No. ... Salmon Idaho ... St.
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Ellen Bell

6. DATE OF BIRTH (month, day and year) June 24th 1849

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	—	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Freighter

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10. NAME OF FATHER Geo Cockrell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Chas Cockrell
(Address) Salmon

15. Filed ...., 19.... ....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 4th, 1930
that I last saw him alive on July 4 1930
and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diarrhoea

.... (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Old age

.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of June 21
Was there an autopsy? No
What test confirmed diagnosis? ....

(Signed) J. S. Wright, M. D.
July 4, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	July 5th 1930
20. Undertaker	Address
J M C Hockett	Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JUL 17 1930

71445

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71289~~

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

45

2. FULL NAME George Ernest Hall

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20th 1882

7. AGE: 48 Years | Months: 4 | Days: 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner (prospector)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Kuhn

9. BIRTHPLACE (city or town) (State or country): Leadville, Colo

PARENTS

10. NAME OF FATHER: James B. Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Himself
(Address)

15. Filed July 10, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th, 1930, to May 28th, 1930
that I last saw him alive on May 28, 1930
and that death occurred, on the date stated above, at 6 15 p.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of colon
About one year (duration) yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cholecystitis
Do not know (duration) yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) Chas F Hammel, M. D.
June 13, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: May 29th 1930

20. Undertaker: Mrs C Doehler
Address: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 17 1930

71446

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11294

PLACE OF DEATH
County of Lemhi
City of Lemhi

Registration District No. 41
Primary Registration District No. 2116
(No. ....)
Local Registrar's No. ....

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Milford Nichols

(a) Residence. No. Salmon 9 yrs St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 16 1913

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
16 yrs	8 mo	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Teadore Ida

PARENTS

10. NAME OF FATHER Leo Nichols

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Monta Thompson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bannock Mont

14. Informant George Nichols
(Address) Salmon Idaho

15. Filed July 10, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19....
and that death occurred, on the date stated above, at 1-30 P m.
The CAUSE OF DEATH* was as follows: Accidentally Shot in left Side of face by himself while cleaning his gun.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? ....

(Signed) Wm C. Doebler Coroner M. D.
6/2, 1930 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	June 3rd 1930
20. Undertaker	Address
Wm C. Doebler	Salmon, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 4 1930

71447

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21297

Local Registrar's No. 12

PLACE OF DEATH

County of Lewis
City of Winchester
Registration District No. 50
Primary Registration District No. 8/37
(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Mrs Nora Austin

(a) Residence. No. Winchester Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of E. A. Austin

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kearney Neb

PARENTS

10. NAME OF FATHER L. — Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kent Iowa
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant E. A. Austin
(Address) Winchester Idaho.

15. Filed 7/6, 1930 R. E. Durrant Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-4, 1930, to July-4, 1930
that I last saw h-- alive on July-4, 1930
and that death occurred, on the date stated above, at 4 1/2 0 m.
The CAUSE OF DEATH* was as follows:
Died Suddenly Pneumonia
Heart, was Head When
Summed.
0 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) 0 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John F. Hurst M. D.
July 4 1930 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cemetery Idaho	7/6 1930

20. Undertaker Vassar Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 4 1930

71448

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71292~~

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 50
Primary Registration District No. 2129.
Local Registrar's No. 13.
(No. Winchester Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Myrna May Shaunessy
(a) Residence. No. Winchester Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept 23 1924

7. AGE Years 5 Months 10 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winchester

PARENTS
10. NAME OF FATHER Wm E. Shaunessy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho,
12. MAIDEN NAME OF MOTHER Julia Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho,

14. Informant Wm E. Shaunessy
(Address) Winchester Idaho.

15. Filed 7/29, 1930 R. E. Dull Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July - 28 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-24, 1930, to July-28, 1930
that I last saw her alive on July-28, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Toxemia of an Acute Nephritis following Septic Throat.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Vincent's Angina.
..... (duration) ..... yrs. ..... mos. 12 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July-27/30
Was there an autopsy? No
What test confirmed diagnosis? Bacteriological Exam.
(Signed) John F. List, M. D.
July-28, 1930 (Address) Winchester Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mission (Clarkson) Date of Burial July-29 1930

20. Undertaker Vassar Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71449

RECEIVED AUG 14 1930

PLACE OF DEATH

County of Lincoln

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. ~~71293~~

Registration District No. 16

Primary Registration District No. 2016

Local Registrar's No. 13

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hyrum A Talley

(a) Residence. No. Richfield Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~Single, Married~~, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug-10-1847

7. AGE: 82- Years; Months: 11- Days: 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: — Talley

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Don't Know

14. Informant: Ida Layne

(Address) Richfield

15. Filed Aug 2 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to Aug 1st, 1930 that I last saw him alive on July 20, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows: Myo Carditis. —

(duration) yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary): Senility. Arteriosclerosis.

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Death.

(Signed) [signature], M. D.

Aug 2, 1930 (Address) Rostar Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place~~ of Burial, Cremation, or Removal: Richfield. Date of Burial: 8-3-1930

20. Undertaker: A. G. Thompson Address: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

71450

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 8291

Registration District No. 1016
Primary Registration District No. 16
Local Registrar's No. 14

PLACE OF DEATH
County of Lincoln
City of Shoshone
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Marie Hansen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Christian Hansen

6. DATE OF BIRTH (month, day and year): Aug 11-1856

7. AGE — Years: 73 | Months: 11 | Days: 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Copenhagen Denmark

PARENTS

10. NAME OF FATHER: Jacobsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Christian Hansen
(Address): Shoshone Idaho

15. Filed Aug 5, 1930 — J. L. Green, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 3, 1930, that I last saw h[illegible] alive on Aug 3, 1930, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Chronic Cholecystitis
(duration) 15 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Phy Exam.
(Signed) T. G. Leggett, M. D.
8/14, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Salt Lake City	
20. Undertaker	Address
E. L. Hickox	Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71452

RECEIVED AUG 14 1930

PLACE OF DEATH

County of Lincoln

City of Shoshone

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 1016

DO NOT WRITE IN THIS SPACE

State File No. 1295

Local Registrar's No. 16

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Tilford Thomason

(a) Residence. No. Resided St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Thomason

6. DATE OF BIRTH (month, day and year) May 13 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	3	17	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Hyram Thomason

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs Cora Crothers

(Address)

15. Filed Aug 12 1930 J. L. Stuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1930, to Aug 11 1930, that I last saw h alive on Aug 11 1930, and that death occurred, on the date stated above, at 1 17 m.

The CAUSE OF DEATH† was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. E. Barrett, M. D.

8/11, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	Aug. 12 1930

20. Undertaker	Address
C E Hickok	Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 15 1930

71453

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Madison

City of Hibbard.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. ~~71297~~

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Earl McKenna.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married. (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 9. (Day) 1900 (Year)

7. AGE: 29 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Utah.

10. NAME OF FATHER: Thomas McKenna.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Rebecca Hendricks.

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. E. McKenna.

(Address) Rexburg Idaho

15. Filed 7/15 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

31

16. DATE OF DEATH: July (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to July 12 1930 that I last saw him alive on July 11 1930, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributor (Secondary) Interstitial nephritis

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) Louis F. Rich M. D.

7/13 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida.

DATE OF BURIAL: July 15 1930.

20. UNDERTAKER: Vern J. Keller

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

71451

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED AUG 15 1930

Registration District No. 100

County of Madison

Primary Registration District No. ~~100~~ 2178

File No. ~~71295~~

City of Rexburg

(No. ..... St.)

Registered No. 34

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois Fay Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): X

6. DATE OF BIRTH: Aug. (Month) 2 (Day) 1927 (Year)

7. AGE: 2 Yrs. 11 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Rexburg Ida.

10. NAME OF FATHER: Robert Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elva Munk.

13. BIRTHPLACE OF MOTHER (State or Country): Rexburg Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Robert Johnson

(Address) Rexburg Idaho

15. Filed 7/22 1930 J Ryonng Local Registrar

MEDICAL CERTIFICATE OF DEATH

121

16. DATE OF DEATH: July (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1930, to July 21 1930, that I last saw her alive on July 20 1930, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Sarcoma of liver

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Anemia

..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Lorin F. Rich M. D.

7/22 1930 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg Ida.

DATE OF BURIAL: July 22 1930

20. UNDERTAKER: Vern J Kellen

ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

71455

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71288~~

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

161a

2. FULL NAME Baby Liddell
(a) Residence. No. 7 St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Daughter of L. C. Liddelle

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days | If LESS than 1 day, 9 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg

PARENTS

10. NAME OF FATHER L. C. Liddelle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Minnie Murri
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St Anthony Idaho

14. Informant L. C. Liddelle
(Address)

15. Filed Aug 1st, 1930 J. Rymmy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930 to July 31, 1930
that I last saw her alive on July 31, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Premature Birth

(duration) yrs. mos. 11 hrs.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? age
(Signed) P. M. Kelly, M. D.
Aug 1, 1930 (Address) St Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. Anthony | Date of Burial: 8/2 1930

20. Undertaker: Russel Flamm | Address: Rexburg Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71456

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~71300~~

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

161a

2. FULL NAME Donald Nelson
(a) Residence. No. Sunnydelle St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~ Son of Delos Nelson

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sunnydelle Idaho

PARENTS

10. NAME OF FATHER: Delos Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Merriam Hodgson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Delose Nelson
(Address): Sunnydelle Idaho

15. Filed 8/7, 1930 J Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~July~~ Aug (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2, 1930, to Aug 2, 1930
that I last saw him alive on Aug 2, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Patulous foramen ovale

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Premature birth

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Lorin F Rich, M. D.
8-7-, 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Archer Cemetary | Date of Burial: 8/3 1930

20. Undertaker: Russel Flamm | Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71457

PLACE OF DEATH
County of Madison
City of Lyman

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

49

2. FULL NAME Ernest Baumgartner

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Mina Baumgartner

6. DATE OF BIRTH (month, day and year) Feb. 17, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Switzerland
(State or country)

PARENTS

10. NAME OF FATHER Albert Baumgartner

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Switzerland

14. Informant Mina Baumgartner
(Address) Rexburg RFD# 2

15. Filed 8/7, 1930 J Rymmy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1929, to Aug 6, 1930
that I last saw him alive on Aug 6 1930
and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of right lung
(duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Carcinoma of face
(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of 1929 Mayo Clinic 1930 Rochester Minn
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & laboratory findings

(Signed) Louis F. Rich M. D.
8-7-, 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Archer Idaho	8/11 1930
20. Undertaker	Address
Russell F. Clamm	Rexburg

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7145 8

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No Rexburg General Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

120

2. FULL NAME Myrtle Estella Raymond

(a) Residence, No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	W	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of W. Wallace Raymond

6. DATE OF BIRTH (month, day and year) March 14 1906

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	4	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... Utah.
(State or country)

PARENTS

10. NAME OF FATHER Burt Grose.

11. BIRTHPLACE OF FATHER (city or town) ..... Utah.
(State or Country)

12. MAIDEN NAME OF MOTHER Adelaide Crockett

13. BIRTHPLACE OF MOTHER (city or town) ..... Utah.
(State or Country)

14. Informant Wallace Raymond
(Address) Rexburg Idaho

15. Filed 8/8, 1930 J. A. Meyers
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Aug 4th 1930
that I last saw her alive on Aug 4th, 1930
and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:
Acute Yellow Atrophy of liver (Toxemia of Pregnancy)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) ..... M. D.
Aug 7, 1930 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Annis Ida.	8/8 1930

20. Undertaker	Address
A. B. Tetherall	Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71459

PLACE OF DEATH
County of Minadoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No. 39
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Louise Albertson 129

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cyrus Albertson

6. DATE OF BIRTH (month, day and year) Nov. 9, 1883

7. AGE Years 46 Months 7 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Snowville
(State or country) Box Elder Co. Ut

PARENTS
10. NAME OF FATHER Hans Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Georgina
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) S. H. Albertson Albion Ida

15. Filed 8-1, 1930 E. H. Elmore Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930 to July 2, 1930
that I last saw her alive on July 2, 1930
and that death occurred, on the date stated above, at 1:50 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis
Nephritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Fayre H. Kerby, M. D.
7-5, 1930 (Address) Rupert Ida

19. Place of Burial, Cremation, or Removal Albion Ida. Date of Burial July 5 1930

20. Undertaker D. E. Johnson Address Burley

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71460

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Daniel Needham

90

(a) Residence. No. 602 - 6th ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Needham

6. DATE OF BIRTH (month, day and year) Apr 5 - 1853

7. AGE Years 77 Months 3 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer self.

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER John Needham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Bridgett —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Susan Needham
(Address) 602 - 6th ave

15. Filed 8-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 11, 1930
that I last saw him alive on July 11, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:

arterio sclerosis
General

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) uremia

(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
July 11, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lancaster Wis
Date of Burial 19

20. Undertaker Vassars
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71461

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Cecil Berlin.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 38. Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Clearwater Timber Co.

9. BIRTHPLACE (city or town) (State or country): Not known.

PARENTS

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant

(Address) Lewiston, Idaho.

15. Filed 8-1-, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 10th, 1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 10, 1930 that I last saw him alive on July 9, 1930 and that death occurred, on the date stated above, at 1800 m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Acute appendicitis

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of July 7 1930

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E G Braddock, M. D.

7/11/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Augusta Wis

Date of Burial 19

20. Undertaker: Brower-Wann Company.

Address: Lewiston

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71462

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. 1613 Carson Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sadie Ann Kunes.

(a) Residence. No. 1613 Carson Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 11th, 1851.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78.	10.	25.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Drigtwood,
(State or country) Pa.

PARENTS

10. NAME OF FATHER Daniel Lupro.
11. BIRTHPLACE OF FATHER (city or town) Not known.
(State or Country)
12. MAIDEN NAME OF MOTHER Jane Collins.
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Pa.

14. Informant Mrs. G. W. Walker.
(Address) Lewiston, Idaho.

15. Filed 7-9-30 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 19 to July 6, 1930
that I last saw h[illegible] alive on July 3, 1930
and that death occurred, on the date stated above, at 2 p.m.
The CAUSE OF DEATH* was as follows:

Cancer of rectum

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
7/7/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gold Hill, Idaho.	7/8/30. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71463

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1409
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

131

2. FULL NAME May Sheehan
(a) Residence. No. Lewiston Hotel St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. Sheehan

6. DATE OF BIRTH (month, day and year) Dec. 24 1886

7. AGE Years 41 Months 6 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Owner.
(b) General nature of industry, business, or establishment in which employed (or employer) Rooming Houses
(c) Name of employer 1

9. BIRTHPLACE (city or town) (State or country) Aubeon N. Dakota

PARENTS
10. NAME OF FATHER William Ransome
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Arena Brunsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J. S. Ransome
(Address) Seattle Wash.

15. Filed 7-5, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to July 4, 1930
that I last saw her alive on July 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Uraemic (Coma)
Poisoning
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis & Chr. interstitial nephritis
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
7-5, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Seattle Washington | Date of Burial 19

20. Undertaker Vassar McCluary Inc. | Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71464

PLACE OF DEATH
County of Nez Perce.
City of Reubens.

Registration District No. 96
Primary Registration District No. 1029

Local Registrar's No.

(No.) 746
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Nugent.

(a) Residence. No. St. Reubens
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) -------- 1870.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60.	----.	----.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER Hugh Nugent.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Bridget McVouge.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Ellen Nugent.
(Address) Reubens, Idaho.

15. Filed 8-1-, 30 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5:45 P. m.
The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Brower Coroner, M. D.
7/6/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	7/7/30. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71465

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Norman Augustus Bigelow.

(a) Residence. No. St. Fenn, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara M. Bigelow.

6. DATE OF BIRTH (month, day and year): Dec. 12th, 1861.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68.	6.	12.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: R. R. Station Agent.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Camas Prairie R. R. Co.

9. BIRTHPLACE (city or town) (State or country): Concord, Michigan.

PARENTS

10. NAME OF FATHER: Elijah K. Bigelow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.
12. MAIDEN NAME OF MOTHER: Carlista Swick.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant: Mrs N. A. Bigelow
(Address): Fenn, Idaho.

15. Filed 8-1, 1930 — J. M. Lyle, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30th, 1930, to July 4, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Apoplexy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ferdinand Idy
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Paralysis
(Signed) H. Larson, M. D.
7/6/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	7/6/30. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71466

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 427 17th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Melvin C. Scott.

(a) Residence. No. 427 17th, St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Highway Employee

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Do

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Do

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Do

14. Informant: E M Brown
(Address) ~~Pullman, Washington~~ Lewiston Idaho

15. Filed 8-1, 1930 J M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E M Brown Coroner M. D.

7/6/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho.

Date of Burial: 7/8/30. 19

20. Undertaker: Brower-Wann Company.

Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71467

PLACE OF DEATH

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St Joseph Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

89

2. FULL NAME Corrie Waterer

(a) Residence. No. 923- 8th St Clarkston Wn St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widoded

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Benson

6. DATE OF BIRTH (month, day and year): January 18, 1874

7. AGE: Years 56, Months 6, Days 5. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: R.R. Freight Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

(c) Name of employer: Camas Prairie R.R.Co.

9. BIRTHPLACE (city or town) (State or country): Colorado

PARENTS

10. NAME OF FATHER: Fred Waterer

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Helen Roger

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Lonnie E. Little (Daughter)
(Address): Grandview, Wash.

15. Filed ___, 19__ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21st, 1930, to July 23rd, 1930 that I last saw him alive on July 23rd, 1930 and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (duration) ___ yrs. ___ mos. — ds.

CONTRIBUTORY (Secondary): Arterio sclerotic (duration) + yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) O C Carson, M. D.

7/24, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Ida. Date of Burial: 7/24/30 19

20. Undertaker: H.R.Merchant Address: Clarkston, Wn

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71468

PLACE OF DEATH
County of Nezperce
City of Lewiston Ida

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

107

2. FULL NAME Dorthy Caroline Silleman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21, 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	1	19	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clarkston, Wash.

PARENTS

10. NAME OF FATHER C.E. Silleman

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spokane, Wash.

12. MAIDEN NAME OF MOTHER Myrtle Kelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Greer, Idaho

14. Informant C.E. Silleman
(Address) Clarkston, Wash.

15. Filed 8-1, 19 30 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 30 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 1, 19 30, to July 10, 19 30
that I last saw her alive on July 10, 19 30
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Pulmonary Oedema.

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pertussis
..... (duration) ..... yrs. ..... mos. 15 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? ..... What test confirmed diagnosis? Thyroid Sugar.
(Signed) William Hatch M. D.
July 10, 19 30. (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Wash/	7/12,30 19

20. Undertaker	Address
H.R. Merchant	Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71469

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 402 - 5th St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME W. Gordon Bevis
(a) Residence. No. 402 - 5th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Sing C

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Nov. 18 1893

7. AGE Years 36 Months 8 Days 3 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Haven Ohio

PARENTS
10. NAME OF FATHER P. R. Bevis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bevis Ohio
12. MAIDEN NAME OF MOTHER Lily White
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Haven Ohio

14. Informant Mrs P. R. Bevis
(Address) Lewiston Idaho

15. Filed ___, 19___ J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1930 to July 26 1930
that I last saw him alive on July 26, 1930
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 4 yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Paul J. Hauser, M. D.
Aug. 4, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 7/29 1930

20. Undertaker Vassar Mortuary Inc
Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71470

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

(No. ~~604 7th, Avenue.~~ .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Herman Leroy Porter.

(a) Residence. No. ..... St. Juliaetta, Idaho. R. F. D. 1 & 2

(Usual place of abode)

Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Addie L. Porter.

6. DATE OF BIRTH (month, day and year) April 18th, 1874.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56.	3.	10.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer and stockman.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER James Porter.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Harriet Simpson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Addie L. Porter

(Address) Juliaetta, Idaho, R. F. D.

15. Filed 8-1, 19 30 W. M. Ryle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Accidental Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Emil Brower M. D.

7/29/30., 19..... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	7/30/30. 19
20. Undertaker	**Address**
Brower-Wann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930
VITAL STATISTICS

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71471

PLACE OF DEATH

County Nez Perce. Registration District No. 96

City Stites Primary Registration District No. 1009

(No. Whites Hospital.) Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alberta Angeline Smith.

(a) Residence. No. St. Lapwai, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	Indian.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 6th, 1929.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1.	1.	19.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pendleton, Oregon.

PARENTS

10. NAME OF FATHER Simon Smith.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stites, Idaho.

12. MAIDEN NAME OF MOTHER Grace Kash Kash.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kooskia, Idaho.

14. Informant Grace Kash Kash Smith

(Address) Lapwai, Idaho.

15. Filed 8-1-30 J. W. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 25th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 25, 1930,
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

T. B. Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General T. B.

(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Casdnal Symptoms

(Signed) E. L. White, M. D.

7/26/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sweetwater, Idaho.	7/28/30. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

71471

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village or
City Lewiston No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Alberta Angeline Smith

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1929

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	5	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Umatilla Reservation
(State or country) Pendleton, Oregon

PARENTS
10 NAME OF FATHER Simon Smith
11 BIRTHPLACE OF FATHER (city or town) Stites
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Grace Kash Kash
13 BIRTHPLACE OF MOTHER (city or town) Sweetwater
(State or country) Idaho

14 Informant Grace Kash Kash
(Address) Lapwai Idaho

15 Filed 7/26/1930 L. A. Maxwell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Whooping Cough
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Lapwai Cemetery
DATE OF BURIAL: July 28 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71472

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1004

Local Registrar's No.

(No. 604 7th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Schyler Colfax Castleman.

(a) Residence. No. St. Boise, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 3rd, 1868.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62.	4.	27.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Building contractor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER Josiah Castleman.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.

12. MAIDEN NAME OF MOTHER ------ Ordway.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine.

14. Informant Mrs S.C. Castleman.
(Address) Boise, Idaho.

15. Filed 8-1-, 1930 J.M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Julu 30th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to July 30, 1930
that I last saw h[illegible] alive on July 30, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular
Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W O Clark, M. D.

7/31/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise, Idaho.	19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71473

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 9c

Primary Registration District No. 1009

Local Registrar's No.

(No. Whites Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

30-A

2. FULL NAME Baby Meiners.

(a) Residence. No. St. Nez Perce, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27th, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
-------	------	----	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER L. C. Meiners.

11. BIRTHPLACE OF FATHER (city or town) Helix,
(State or Country) Oregon.

12. MAIDEN NAME OF MOTHER Ruth Smathers.

13. BIRTHPLACE OF MOTHER (city or town) Gifford,
(State or Country) Idaho.

14. Informant L. C. Meiners
(Address) Nez Perce, Idaho.

15. Filed 8-1-30 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/27-1930, 19..., to 7/27-1930, 19...
that I last saw h[illegible] alive on 7/29-1930, 19...
and that death occurred, on the date stated above, at 330 p. m.
The CAUSE OF DEATH* was as follows:

Patulent foramen ovale.

5½ hours.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms

(Signed) J. H. Poland, M. D.
7/28/30., 19... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nez Perce, Idaho.	7/28/30. 19

20. Undertaker Brower-Wann Company. Address Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71471

PLACE OF DEATH
County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1803
Local Registrar's No.
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

187

2. FULL NAME George R Allbright

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Parsons

6. DATE OF BIRTH (month, day and year) Aug. 6, 1903

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	11	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ile, Idaho (Now Craigmont, Ida.)

PARENTS

10. NAME OF FATHER Edward O Allbright
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Martha Bolick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Mrs Victoria Allbright (Wife)
(Address) Anatone, Wash

15. Filed 8-1, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7/ (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Bull Wheel of Combined Harvester
run over lower abdomen.
Accidental Death
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J M McElvain M. D.
7/23, 1930 (Address) Asotin Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clarkston, Wash	7/25/30
20. Undertaker	Address
H R Merchant	Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71475

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Robert N. Frederickson.

(a) Residence. No. Lewiston Orchards. XX
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 26th, 1874.

7. AGE: Years 55. Months 6. Days 22. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Melbourne, Australia.

PARENTS

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Mary Nelson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant Nitta M. Frederickson.
(Address) Lewiston, Idaho.

15. Filed 7-18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to July 17, 1930
that I last saw him alive on July 16, 1930
and that death occurred, on the date stated above, at 1 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma cervical
Lymph glands (Primary)
Bilateral (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinonoma
Brain (Metastatic) (duration) yrs. 2 mos. 20 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? microscopic examination of tissue from neck

(Signed) [signature], M. D.
7/18/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 7/20/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71476

PLACE OF DEATH
County of Van Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1609
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Ace E Ailor

(a) Residence. No. St. Johnson Wash 71a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Thelma Ailor

6. DATE OF BIRTH (month, day and year) July 9 - 1899

7. AGE Years 31 Months 0 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS
10. NAME OF FATHER Jacob F Ailor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Carrie Shields
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky

14. Informant Glenn Ailor
(Address) Grangeville

15. Filed 8-1- 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 17, 1930
that I last saw him alive on July 17, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ruptured frontal
Sinus, accidental (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Xray
(Signed) J H Crampton, M. D.
7-17, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pullman Wn
Date of Burial 19

20. Undertaker Vassar Mortuary Inc
Address Lewiston

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71477

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205-a

2. FULL NAME Roberta Francis McNeil.

(a) Residence. No. 1222 2nd, St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 14th, 1930.

7. AGE Years: ------. Months: ----. Days: 2. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Idaho.

PARENTS

10. NAME OF FATHER H. R. McNeil.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan.

12. MAIDEN NAME OF MOTHER Juanita Lawrence.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Coolie City, Washington.

14. Informant H. R. McNeil
(Address) Lewiston, Idaho.

15. Filed 8-1-, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/14-30, 19, to 7/16-30, 19
that I last saw her alive on 7/16-30, 19
and that death occurred, on the date stated above, at 1:15 A. m.

The CAUSE OF DEATH* was as follows:

Patulent foramin ovale.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms.

(Signed) H. Rouse, M. D.

7/16/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 7/16/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71479

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Concord in rear)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Helen Callan

(a) Residence. No. Starbuck Wash St. (Usual place of abode) 182 Starbuck Wash. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	11			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Culdesac Idaho.

PARENTS

10. NAME OF FATHER Tom Callan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grangeville Idaho

12. MAIDEN NAME OF MOTHER Rhoda Farmer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas.

14. Informant Mrs. Callan
(Address) Lewiston Idaho

15. Filed 8-1, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Drowning
Accidental
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. W. Bowers M. D.
7/16, 1930 (Address) Lewiston Coroner Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	7/17 1930
20. Undertaker	Address
Vassar Mortuary	Lewiston.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71479

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Gladys Budig

(a) Residence. No. East Lewiston St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Walla Walla Wash.

PARENTS

10. NAME OF FATHER Joseph Budig
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria
12. MAIDEN NAME OF MOTHER Julia Baron
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Austria

14. Informant Jos Budig
(Address) Lewiston Idaho

15. Filed 8-1, 1930 J. M. Kyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 2:30 p.m.
The CAUSE OF DEATH* was as follows:
accidental Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. M. Bowers M. D.
7/15, 1930 (Address) Lewiston Idaho,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	7/17 1930

20. Undertaker Cassas Mortuary Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71489

PLACE OF DEATH
County of Nez Perce
City of Reubens

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No. 31

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Violet Edna Wilfong

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hugh Allen Wilfong

6. DATE OF BIRTH (month, day and year) Mar 28 1902

7. AGE Years	Months	Days	If LESS than 1 day,
28	3	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) Davis County
(State or country) Missouri

PARENTS

10. NAME OF FATHER Charles L. Boyd

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Frances E. Burress

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Iowa

14. Informant Hugh A Wilfong
(Address) Gifford, Ida.

15. Filed 7- 12, 1930 E E Watts
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1930
~~June 14~~ (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14, 1930, to July 12, 1930
that I last saw her alive on July 12, 1930
and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:
Endocarditis

(duration) — yrs. — mos. 30 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) E E Watts, M. D.
7- 12, 1930 (Address) Gifford

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~	Date of Burial
Lookout Cemetery	7- 13 1930

20. Undertaker	Address
Craigmont Hdwe Co E E Evans	Craigmont Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71481

PLACE OF DEATH

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

Local Registrar's No. 27

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Byron Leigh

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 4. 30

7. AGE Years Months Days If LESS than 1 day 7 hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad Ida.

PARENTS

10. NAME OF FATHER Byron J. Leigh

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Ida

12. MAIDEN NAME OF MOTHER Emily J. Wakley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kaysville Utah

14. Informant Mrs Daniel Leigh
(Address) Malad

15. Filed 7/31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4, 10 AM, to 5 P.M. July 4, 1930

that I last saw h..... alive on ....., 19..

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Premature patent foramen ovale. 7½ mos.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? "blue baby"

(Signed) V. P. Garst, M. D.

July 5, 1930 (Address) Malad, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida

Date of Burial July 5 1930

20. Undertaker J. Guy Benson

Address Malad Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71482

PLACE OF DEATH

County of RECEIVED AUG 4 1930

City of

Registration District No. 16

Primary Registration District No. 2069

Local Registrar's No. 28

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Elroy Applegood

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 7 1924

7. AGE — Years: 5 | Months: 8 | Days: 23 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Malad Idaho

PARENTS

10. NAME OF FATHER: Frank L. Applegood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wanship Utah

12. MAIDEN NAME OF MOTHER: Sarah Dudley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Cherry Creek Idaho

14. Informant: Frank L. Applegood
(Address): Malad Ida

15. Filed 7/31, 1930 — J. M. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 11 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 11, 1930
That I last saw him alive on July 11, 1930, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows: diphtheria

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? culture

(Signed) M. D.

7/14, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida — Date of Burial: July 13 1930

20. Undertaker: J Guy Benson — Address: Malad

IMPORTANT—Every item of information should be carefully supplied. Your signature should be written plainly. Exact statement of OCCUPATION is very important. See instruction on back of certificate. CAUSE OF DEATH in plain terms, so that it may be properly classified.

RECEIVED AUG 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71483

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 29
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Madsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Ann A. Clark.

6. DATE OF BIRTH (month, day and year) Sept 20-1875

7. AGE	Years	Months	Days	If LESS than 1 day,
	54	9	28	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Salem
(State or country) Utah

PARENTS

10. NAME OF FATHER James Madsen

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER Birgitha Jensen

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Denmark

14. Informant Hattie M. Knight
(Address) Blackfoot Ida.

15. Filed 7/31, 1930 J. M. Kress
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to July 18, 1930
that I last saw him alive on July 17, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart.
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Pneumonia.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Idaho	July 20 1930

20. Undertaker J. Guy Henson Address Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71481

PLACE OF DEATH
County of Owyhee
City of Grandview
Registration District No. 74
Primary Registration District No.
(No. Grandview, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

164

2. FULL NAME William Henry Jameson

(a) Residence. No. Grandview, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of May 25th 1852

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stone Mason.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine.

14. Informant Mrs. George Rocks.
(Address) Grandview, Idaho.

15. Filed July 14, 1930 W. J. Eckenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about a year, 19..., to ..., 19...
that I last saw her alive on July 7, 1930
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
(Senility) Terminal pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm. J. Eckenbeck, M. D.
July 11, 1930 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	7/13/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71485

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Owyhee
City of Bruneau

Registration District No. 74
Primary Registration District No. 2151
Local Registrar's No. 58
(No.) 746
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Leachman Benham.
(a) Residence. No. Bruneau Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jannie Benham.

6. DATE OF BIRTH (month, day and year) 8-1-1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Richard Benham.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky.
12. MAIDEN NAME OF MOTHER Matilda Leachman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ken.

14. Informant (Address) Mrs. Jannie Benham Bruneau Ida.

15. Filed July 21/30, 19..... W J Eckenbeck Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7- (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-4, 1930, to 7-15-, 1930
that I last saw him alive on 7-14-, 1930
and that death occurred, on the date stated above, at 4:55 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) L. C. Evans, M. D.
7-18-, 1930 (Address) Mtn. Home Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bruneau Ida.	7-17 1930

20. Undertaker D. S. Barker Address Mt. Home Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71486

PLACE OF DEATH

County of Power
City of American Falls
Registration District No. 23-
Primary Registration District No. 2072
Local Registrar's No. 12
(No. Bethany Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. FULL NAME Jeanette Risser

(a) Residence. No. ____ St. ____
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24 1930

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
—	—	—	14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) American Falls
(State or country) Idaho

PARENTS

10. NAME OF FATHER Otto G Risser

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wisner Nebraska

12. MAIDEN NAME OF MOTHER Marie Louise Tiahrt

13. BIRTHPLACE OF MOTHER (city or town) Beatrice Neb
(State or Country)

14. Informant Otto G Risser
(Address) Aberdeen Ida

15. Filed July 1, 1930 Genevieve Nott
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 25- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1930 to June 25 1930
that I last saw h[illegible] alive on June 24, 1930
and that death occurred, on the date stated above, at 5-30 A m.

The CAUSE OF DEATH* was as follows:
Premature birth - 26 wk - Cause. Placenta praevia Lateralis.

(duration) yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) M. C. Mackinnon, M D
6-25-, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen Idaho	June 26 1930
20. Undertaker Friends	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71487

PLACE OF DEATH
County of Power
City of American Falls
R 70

Registration District No. 25
Primary Registration District No. 2072
(No.)
Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gilbert Curtis Peck 190

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 26 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER George Peck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bingham Utah
12. MAIDEN NAME OF MOTHER May Fifield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Weston Idaho

14. Informant George Peck
(Address) American Falls Ida

15. Filed July 3 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19—, to — 19—
that I last saw him alive on — 19—
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Suffocation. An accident.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) M. C. MacKinnon M. D.
7-3 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland	7-3 1930
20. Undertaker	Address
Friends	

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71488

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 14

(No. 144)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Risser

(a) Residence. No. Bethony Hospital St. Aberdeen Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of O.G.Risser

6. DATE OF BIRTH (month, day and year) Dec 3 1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	7	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb

PARENTS

10. NAME OF FATHER C. . Tiahrt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Anna Wiebe

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Otto G Risser
(Address) Aberdeen, Idaho

15. Filed July 5, 1930. Genevieve Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to July 4, 1930

that I last saw her alive on July 4, 1930

and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows:

Acute Pelvic Peritonitis with abscess. (Puerperal)
Acute Appendicitis
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) General Peritonitis
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 3 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. C. MacKinnon, M. D.

July 4, 1930 (Address) Aberdeen, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Homestead Church	7/7 1930

20. Undertaker Bingham & Davis Address American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71489

PLACE OF DEATH
County of Power
City of American Falls

Registration District No. 25
Primary Registration District No. 2072
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Luca S. McCullough
(a) Residence. No. 451 Tyhee St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of S.H.McCullough

6. DATE OF BIRTH (month, day and year) May 28 1855

7. AGE: Years 75, Months 1, Days 8. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House-wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS
10. NAME OF FATHER Perry H. Saunders
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Sarah Emerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant S. H. McCullough
(Address) American Falls Idaho

15. Filed July 8, 1930 Gunnison Nolt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 6, 1930
that I last saw her alive on July 8, 1930
and that death occurred, on the date stated above, at 12:20 a m.
The CAUSE OF DEATH* was as follows: Dilatation of heart following a hypertrophied condition. This due to fibroid condition (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Lung of many years standing (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Observation over 1 yr
(Signed) C. S. Schultz, M. D.
7/8/30, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F. Cemetary
Date of Burial: 7/9 1930

20. Undertaker: A W Davis
Address: American Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71490

PLACE OF DEATH

County of Power
City of American Falls, Idaho
Registration District No. 23
Primary Registration District No. 2079
Local Registrar's No. 16

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Magnolia U McCombs

(a) Residence. No. at Neeley, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emery McCombs

6. DATE OF BIRTH (month, day and year) March 29th 1903

7. AGE	Years	Months	Days	If LESS than 1 day,
	27	3	26	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morgan, Utah

PARENTS

10. NAME OF FATHER Earnest Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Idah Smith

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Emery McCombs
(Address) American Falls, Idaho

15. Filed July 26, 1930 Genevieve North Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 25th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to July 25, 1930
that I last saw her alive on July 24, 1930
and that death occurred, on the date stated above, at 3:45 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. J. Schultz, M. D.
7/25/30, 19 (Address) American Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Preston, Idaho	
20. Undertaker A W Davis	Address American Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7149

"Most complete copy."

PLACE OF DEATH

County of Shoshone

City of Kellogg

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 40

(No. Wardner - Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Frank Pearl Wilson

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 21 1894

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER John Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) no city

12. MAIDEN NAME OF MOTHER Etta May Galbreath

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Washington Indiana

14. Informant (Address) Mrs. Jessie Fisher Blytheville Ark.

15. Filed 7/30, 1930 Mrs. Helen M. Bird Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930 to July 28, 1930 that I last saw him alive on July 28, 1930 and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Shock - produced by an auto mobile accident - causing compound fracture right leg with hemorrhage and internal injuries causing hemorrhage into the peritneal cavity Accident happened on highway about 28 miles away at (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY: (Secondary) 3 P.M. - was brought to hospital (Wardner.) about 10 min. before he died. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Geo. H. Kennett, M. D.

7/30, 1930 (Address) Kellogg - Ida

19. Place of Burial, Cremation, or Removal Blytheville Ark. - Date of Burial July 30 1930

20. Undertaker M. C. Thornhill Address Kellogg - Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ....

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 220
Local Registrar's No. 40

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Earl Wilson

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ....

6. DATE OF BIRTH (month, day and year) April 21, 1899

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
31	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER John Wilson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Miss Sheldon
(Address) St Regis Montana

15. Filed 7/30, 1930 Mrs. Helen M. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 28, 1930
that I last saw h[illegible] alive on July 28, 1930
and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH* was as follows:
Shock produced by an auto mobile accident causing com pound fracture right leg with hemorrhage and internal (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) hemorrhage caused by accident to peritoneal cavity. Injured on highway about 11:30 and was brought to the hospital (Wardner) about 2 hours after accident
18. Where was disease contracted if not at place of death? ....
Did an operation precede death? .... Date of ....
Was there an autopsy? ....
What test confirmed diagnosis? before he died.

(Signed) Leon H Kennett, M. D.
7-30, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blytheville, Ark.	July 30 1930

20. Undertaker .... Address ....
M. P. Thornhill Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71493

PLACE OF DEATH
County of Shoshone
City of Mace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

140

2. FULL NAME Constance May Wilmoth

(a) Residence. No. Mace, Idaho St. Mace Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 26 - 193

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho

PARENTS

10. NAME OF FATHER Ray Wilmoth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Castle Colorado
12. MAIDEN NAME OF MOTHER Elva Reece
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Butte Mont

14. Informant Ray Wilmoth
(Address)

15. Filed June 30, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h[illegible] alive on , 19
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows: Myocardial Degeneration Status Epilepticus

(duration) 1 hour

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? N/A
Did an operation precede death? N/A Date of
Was there an autopsy? N/A
What tests confirmed diagnosis? N/A

(Signed) C. W. Avery M.D.
6/29, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	June 30 1930
20. Undertaker J. A Bower	Address Wallace, Ida
Ward and Co.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71491

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 62

41

2. FULL NAME Robert Gerald Whiteside
(a) Residence. No. Mullan, Idaho St. Mullan Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30 - 1920

7. AGE Years 19 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gold Hunter Mng Co.

9. BIRTHPLACE (city or town) (State or country) Midvale Idaho

PARENTS
10. NAME OF FATHER Edwin F Whiteside
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Effie May Rader
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant E. K. Whiteside.
(Address) Mullan, Idaho.

15. Filed Jul 23, 1930 L. Lingley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930 to June 21, 1930
that I last saw him alive on June 21, 1930
and that death occurred, on the date stated above, at 12:30 m.
The CAUSE OF DEATH* was as follows:
Septicaemia Gen-eral
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Carbuncle Elbow
(duration) yrs. mos. 7-8 ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowery, M. D.
6/22, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Shipped to Moscow
Date of Burial June 23 1930

20. Undertaker J. A. Bever Ward Mud Co.
Address Wallace, Ida.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71495

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1111
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 61

124

2. FULL NAME Irwin Harrington
(a) Residence. No. Mullan, Idaho St. Mullan, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 14 - 1929

7. AGE Years Months 9 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Black Bear - Ida.

PARENTS
10. NAME OF FATHER Irwin Harrington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fort Collins Colorado
12. MAIDEN NAME OF MOTHER Evangela Koshier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mullan Idaho

14. Informant Irwin Harrington
(Address) Mullan, Idaho

15. Filed Jun 22, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1930, to June 19, 1930
that I last saw her alive on June 19, 1930
and that death occurred, on the date stated above, at 7:15 P.m.
The CAUSE OF DEATH* was as follows:
General peritonitis
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Erysipelas
(duration) yrs. mos. 17 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Physical Exam
(Signed) R. Werbel, M. D.
June 20, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho
Date of Burial June 22 1930

20. Undertaker J. A. Bever Ward Und Co.
Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71496

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

2. FULL NAME Pearl Gladys Blackman

(a) Residence. No. Murray Idaho St. Murray Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Blackman

6. DATE OF BIRTH (month, day and year) Dec 16-1883

7. AGE 46 Years | Months 6 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lafayette Ore

PARENTS
10. NAME OF FATHER John Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Julia Johnston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Mrs L. Winters
(Address) Portland, Ore

15. Filed June 1, 1930 L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930 to June 17, 1930
that I last saw her alive on June 16, 19..
and that death occurred, on the date stated above, at 2:30 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Rt side left analysis
Nephritis Year
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Nephritis & Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowery, M. D.
6/17, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Murray Ida. | Date of Burial June 1930

20. Undertaker J. A. Bever Ward Lind Co. | Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71497

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

31

2. FULL NAME Oscar Larson

(a) Residence. No. Mullan, Idaho St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.
6. DATE OF BIRTH (month, day and year) Nov 25 - 1880
7. AGE Years 49 Months 6 Days 20 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gold Hunter Mng Co.
9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER Carl Oscar Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Carl Larson
(Address) E 717 - 38 - St. Spokane Wn

15. Filed June 17, 1930 F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to June 15, 1930
that I last saw him alive on June 15, 1930
and that death occurred, on the date stated above, at 9:30 p.m.
The CAUSE OF DEATH* was as follows:
Pulmonary hemorrhage
(duration) ..... yrs. ..... mos. 1 hour ~~ds.~~
CONTRIBUTORY (Secondary) Pulmonary tuberculosis
(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical examination
(Signed) R. C. Werlic M. D.
June 16, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wn
Date of Burial June 18 1930
20. Undertaker J. A. Bowler Ward Mnd Co.
Address Wallace, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71498

Registration District No. 70

Primary Registration District No. 1911

Local Registrar's No. 58

(No. Providence Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME C. B. Ferguson

(a) Residence. No. Murray, Idaho. St. Murray, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word). Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE 65 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10. NAME OF FATHER Samuel S Ferguson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Lucille Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Mrs Elizabeth Manning

(Address) Reno, Nev.

15. Filed June 15, 1930 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2, 1930 to June 12, 1930

that I last saw him alive on June 12, 1938

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer Liver

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Doris Mowary, M. D.

6/13, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Murray Ida. | Date of Burial June 15 1930

20. Undertaker A. Bever Ward Und Co. | Address Wallace, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71499

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 10171
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

2. FULL NAME Edna Madeline Webster

(a) Residence. No. Burke Idaho St. Burke Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 14 Months 11 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Billings Mont

PARENTS
10. NAME OF FATHER A. H. Webster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) B. C.
12. MAIDEN NAME OF MOTHER Eliza Kirby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. J.

14. Informant Mr A H Webster
(Address) Burke Idaho

15. Filed June 14, 1930 F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to June 12, 1930
that I last saw her alive on June 12, 1930
and that death occurred, on the date stated above, at 5:30 p.m.
The CAUSE OF DEATH* was as follows:
Carbonitis Suppur
Streptococcic
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Appendicitis Suppur (duration) yrs. 4-5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 6/11
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. McWerry M. D.
6/13, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho
Date of Burial June 14 1930

20. Undertaker J. A. Bever Ward Und Co.
Address Wallace, Ida.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71500

PLACE OF DEATH
County of Shoshone
City of Clarkia

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

205-B

2. FULL NAME Unknown.
(a) Residence. No. Clarkia. St. Clarkia.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Not Known — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Apparently Logger.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Shoshone Co. Sherriff.
(Address) Wallace, Idaho

15. Filed June 14, 1930 D. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Found May 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Remains found near Clarkia Ida
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None Known
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) K. Mowry Corone, M. D.
6/14 1930 Address Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial June 14 1930
20. Undertaker J. A. Beer Ward Und Co. Address Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71501

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70.
Primary Registration District No. 1011
(No. Co Infirmary)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

31

2. FULL NAME Vernon Kelling
(a) Residence. No. Mullan, Idaho St. Mullan Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 18 - 1909

7. AGE Years 21 Months 4 Days 22 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10. NAME OF FATHER Jack Macki
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Hilma Doctor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Jack Macki
(Address) Mullan, Idaho.

15. Filed June 12, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to June 10, 1930
that I last saw her alive on June 9, 1930
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
6/11/30 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho. Date of Burial 6/12/30

20. Undertaker J A Bever Wadsworth Co. Address Wallace, Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JUL 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71502

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 54

2. FULL NAME Julius Gustaf Pflug.
(a) Residence. No. Mullan Idaho St. Mullan 31
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Annette Pflug.

6. DATE OF BIRTH (month, day and year) Nov 11 1866

7. AGE 63 Years 6 Months 18 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Millman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gold Hunter Mng Co.

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10. NAME OF FATHER Gotthold Pflug.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Annette Pflug
(Address) Mullan Idaho.

15. Filed June 12, 1930. T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930 to June 9, 1930
that I last saw him alive on June 8, 1930
and that death occurred, on the date stated above, at 4:30 A m.
The CAUSE OF DEATH* was as follows:
Hemorrhage
T. B.
(duration) ? yrs. ? mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F W Ralf, M. D.
June 10, 1930 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan Idaho
Date of Burial June 12 1930

20. Undertaker J. A. Bower Ward Ward Co.
Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71503

PLACE OF DEATH
County of Twin Falls
City of 11 11

Registration District No. 37
Primary Registration District No. 1085
(No. 1201 8th Ave East)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

47

2. FULL NAME Katherine Deven

(a) Residence. No. 1201 8th Ave East St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 11 1867

7. AGE Years 62 Months 7 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ill.
(State or country)

PARENTS

10. NAME OF FATHER Michel Deven
11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)
12. MAIDEN NAME OF MOTHER Julia Moran
13. BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country)

14. Informant
(Address)

15. Filed August 6th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24th, 1930, to July 1st, 1930, that I last saw her alive on June 30th, 1930, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pericarditis Endo Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilation Heart. Hypo Static Congestion lungs

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Duncan L. Alexander M. D.
7-2-30, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Delevan Ill
Date of Burial 19

20. Undertaker J. L. Grossman Twin Falls
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71504

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Daniel D. Ryan

(a) Residence. No. 1319 - 8th Ave E. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Ryan

6. DATE OF BIRTH (month, day and year): Nov 16 - 1868

7. AGE: 61 Years, Months: 7, Days: 14. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): E. T. City Utah

PARENTS
10. NAME OF FATHER: Daniel Ryan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Bridget Milan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs. Grace Ryan
(Address) 1319 - 8th Ave E.

15. Filed August 6th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th, 1930, to July 1st, 1930
that I last saw him alive on July 1st, 1930
and that death occurred, on the date stated above, at 11:05 P. m.
The CAUSE OF DEATH* was as follows:

Perinephritis abscess Lesh
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Hypertrophic Prostate
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of June 30
Was there an autopsy? No
What test confirmed diagnosis? Operation Examination
(Signed) Duncan L. Alexander, M. D.
7/2/30, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: 7 - 5 1930

20. Undertaker: White Mortuary Inc
Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71505

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

99

2. FULL NAME Charles A. Schwendinger
(a) Residence. No. 119 - 8th Ave N. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Schwendinger

6. DATE OF BIRTH (month, day and year) Jan 5 - 1886

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Insurance man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Aspen Colo.

PARENTS

10. NAME OF FATHER Joseph Schwendinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary Nutt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant H. J. E. Schwendinger
(Address) Nampa Ida.

15. Filed August 16th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 3, 1930, that I last saw h— alive on July 3, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Clinical only
What test confirmed diagnosis?
(Signed) Anderson, M. D.
July 4, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa - Ida	7-6 1930

20. Undertaker	Address
White Mortuary Inc	Twin Falls, Ida.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71506

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Elias Russell

(a) Residence. No. Twin Falls Ida R.R. #2 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha S. Russell

6. DATE OF BIRTH (month, day and year) March 24-1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Somersetshire England

PARENTS

10. NAME OF FATHER Wm Elias Russell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Jane Palmer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) English

14. Informant Mrs. Ester Wise
(Address) Twin Falls. Ida R.R. #2

15. Filed August 16th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to July 6, 1930
that I last saw him alive on July 6, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Cancer of vertebrae

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X Ray

(Signed) Chas. R. Scott M. D.
July 7, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	July 1930
20. Undertaker White Mortuary Inc	Address Twin Falls. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71508

PLACE OF DEATH
County of Twin Falls
City of Hansen

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 37

(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Keith C. Barnes

(a) Residence. No. Castleford R.F.D. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Grace Barnes

6. DATE OF BIRTH (month, day and year) Jan 13 1899

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	31	5	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranch Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ark.

PARENTS

10. NAME OF FATHER John Barnes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark.
12. MAIDEN NAME OF MOTHER Ida Walden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ark

14. Informant Mrs. Keith C. Barnes
(Address) Castleford Idaho

15. Filed July 14, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-July, 1930, to 9-July-, 1930
that I last saw him alive on 9-July-, 1930
and that death occurred, on the date stated above, at 11:45 A m.
The CAUSE OF DEATH* was as follows:
Septicemia - meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) J.W. MacNamara, M. D.
19-July-, 1930 (Address) Burke, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Ida.	July 14 1930

20. Undertaker T.J. Donovan Address Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71509

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. 1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

45

2. FULL NAME Chas L. French
(a) Residence. No. Twin Falls St. Dr Alexander
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 74 Months 4 Days 0 If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): N Y
PARENTS
10. NAME OF FATHER: C L French
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Mary Dupenberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland
14. Informant: Katherine French
(Address) Twin Falls
15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 10 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to July 10th, 1930 that I last saw him alive on July 10th, 1930 and that death occurred, on the date stated above, at 2-30 P.M.
The CAUSE OF DEATH* was as follows: Carcinoma of the sigmoid
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) none!
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H S Lomb, M. D.
July 12, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier Ida Date of Burial: July 1930
20. Undertaker: T E Drake Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71510

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

101B

2. FULL NAME Josephine Reed
(a) Residence (Usual place of abode) No. Milford Utah St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Reed
6. DATE OF BIRTH (month, day and year) July 5 1886
7. AGE Years 44 Months 0 Days 7 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Kans.

PARENTS
10. NAME OF FATHER Frances Le Breux
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Wm. J. Reed
(Address) Milford Utah
15. Filed July 14, 1930 Elizabeth J Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 6th, 1930, to July 12, 1930
that I last saw her alive on 11 A M July 12 1930
and that death occurred, on the date stated above, at 7:30 m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H E Lamb, M. D.
July 13, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rosepille Calif. Date of Burial 19
20. Undertaker P J Grossman Address Twin Falls

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71511

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
(No. 353 - 3rd Ave East)
Local Registrar's No. 37
(If death occurred in a hospital or institution, give its name instead of street and number.)

196

2. FULL NAME Lyle Wayne Lee

(a) Residence. No. Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 5, 1920

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work =
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Lemuel Lee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Elsie Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs. Elsie Lee
(Address) Twin Falls.

15. Filed July 14, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/12/30, 19..., to ..., 19..., that I last saw him alive on ..., 19..., and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:
Accidental electrocution in bath tub. Electric light cord fell in tub.
(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.
7/14, 1930, (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer	July 15 1930

20. Undertaker Filer Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 14 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

File No. 7151 2

County of Twin Falls

City of Twin Falls (No. South of Twin Falls St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Infant~~ Margret Brady

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 10 (Day) 1930 (Year)

7. AGE: ....Yrs. ....Mos. 11 ds. IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Co. Hospital Twin Falls, Idaho

10. NAME OF FATHER: Joel Alexander Brady

11. BIRTHPLACE OF FATHER (State or Country): Gary, Okla.

12. MAIDEN NAME OF MOTHER: Barbara Faye Stanley

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Brady
(Address) Twin Falls, Ida

15. Filed August 6th 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1930, to July 12 1930, that I last saw her alive on July 11 1930, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth
(Eighth month gestation)

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary): Atelectasis

....(Duration ....yrs. ....mos. ....ds.

(Signed) C. D. Weaver M. D.

19.... (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls cemetery — DATE OF BURIAL: 7/12 1930

20. UNDERTAKER: F. C. Drake — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED AUG 14 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7153

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of ... (If not in incorporated limits, give township.)

Registration District No. 37

Primary Registration District No. 1085

(No. at home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stella Irene Stemplemoser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH. Feb. (Month) 18 (Day) 1909 (Year)

7. AGE: 21 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: R A Junker

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lula Morgan

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R A Junker

(Address) Twin Falls

15. Filed July 16 1930 Elizabeth J Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1930, to July 13 1930, that I last saw her alive on July 13 1930, and that death occured on the date stated above, at 6.30 am M.

The CAUSE OF DEATH* was as follows:

Acute yellow Atrophy of Liver

(Duration) ... Yrs. ... mos. 28 ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) H Wilson M. D.

July 16 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: July 16 1930

20. UNDERTAKER: W E Grossman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7151

PLACE OF DEATH
County of Twin Falls
City of Do

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls Co Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74A

2. FULL NAME Simon Henry

(a) Residence. No. Rainey, near Berger St. Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 17 - 1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER George Henry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant A. L. Henry (Son)
(Address) Berger, Idaho.

15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 15, 1930, that I last saw him alive on July 15, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Stroke

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage of the brain (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) H. M. Lecle, M. D.
July 15, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls cemetery	July 18 1930

20. Undertaker F. C. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71515

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Ed Fay Darnell

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 1914

7. AGE Years 15 Months 6 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Okla

PARENTS

10. NAME OF FATHER J. A. Darnell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Olive Phelps
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs. Shover
(Address) Filer Ida

15. Filed August 6th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gunshot Wound Self inflicted not determined if accidental or intentional (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? yes
(Signed) F. E. Drake Coroner, M.D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Date of Burial July 19 1930

20. Undertaker F. E. Drake Address Twin Falls

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71516

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1185
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME Elizabeth Deseret Budge
(a) Residence. No. Rockland, Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Jan 8/1875
7. AGE: 55 Years, Months: 6, Days: 11, If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: Joseph Allen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Lucinda Lasley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Lucinda Lasley
(Address) Rockland, Ida.
15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 16 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to July 16, 1930
that I last saw her alive on July 16, 1930
and that death occurred, on the date stated above, at 11 45 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Intestinal Tract
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Chr. Nephritis & Senile Gangrene
(duration) 10 yrs. 5 mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Russell Weaver, M. D.
July 16, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rockland
Date of Burial: July 19 1930
20. Undertaker: F. C. Drake
Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7151

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
(No. Nazarene Church)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Anna M Roscoe

(a) Residence. No. 520 2nd East St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 18 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	69	10	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Vermount

PARENTS

10. NAME OF FATHER J. B. Wilkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Harriet Gummis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Paul Steiner
(Address)

15. Filed August 16th 1930 Elizabeth J Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on July 20, 1930, to July 20, 1930
that I last saw her alive on July 20, 1930
and that death occurred, on the date stated above, at 1-PM m.
The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ordinary
(Signed) H Wurton, M. D.
July 22, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	July 22 1930

20. Undertaker: C J Grossman Twin Falls

Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71519

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 2085
(No. Co Gen. Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

20-A

2. FULL NAME Stella B Smith

(a) Residence. No. Buhl St. Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jack Smith

6. DATE OF BIRTH (month, day and year) Don't Know

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
about	44			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Thomas Potts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Louise McDaniels
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Chas C Potts
(Address) Buhl Idaho R 4 Box 3

15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1928, 19__, to 1930, 19__
that I last saw her alive on 19 July, 1930
and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:
exhaustion

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystis kidneys
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Colorado
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory (?)
(Signed) F. W. MacMannis, M. D.
21 July, 1930 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Idaho	July 21 1930
20. Undertaker P. J. Grossman	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71519

PLACE OF DEATH
County of Twin Falls
City of Ditto
Registration District No. 37
Primary Registration District No. 1086
(No. Twin Falls Co. Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence Edward Hollenbeck 41

(a) Residence. No. 1302 -addison ave, east St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 31st 1909

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rupert, Idaho

PARENTS

10. NAME OF FATHER W. J. Hollenbeck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Jennie Kerr
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant W. J. Hollenbeck
(Address) Twin Falls, Idaho

15. Filed August 6th, 1930 E. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 22, 1930, that I last saw him alive on July 22, 1930, and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:
General Streptococcic Septicaemia
(duration) About mos. 10 ds.
CONTRIBUTORY (Secondary) Tonsillectomy (Local)
(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Tonsillectomy July 9th
Was there an autopsy? No. Findings of Gross neck.
What test confirmed diagnosis?

(Signed) W/o Chas Hetherbee by C A Imes M. D.
July 22, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	7/24/30
20. Undertaker Paul Reed	Address Twin Falls.

F IDAHO

RECEIVED AUG 14 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71520

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

(No. Twin Falls County Hosp.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

157

2. FULL NAME J. E. Agee

(a) Residence. No. — St.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	—	—	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Ranch work

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Twin Falls County Hosp.

(Address) Twin Falls Ida.

15. Filed August 6th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/24, 1930, to 7/27, 1930

that I last saw him alive on 7/26, 1930

and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Raynaud's disease

(duration) yrs. 7 mos. 3 ds.

CONTRIBUTORY (Secondary) Gangrene of leg and hip.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/6/30

~~Was there an autopsy?~~ Amputation of leg.

What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.

7/28, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Twin Falls Idaho	7/30 1930
20. Undertaker	Address
White Mortuary	Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71521

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. Twin Falls County Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

143a

2. FULL NAME Alice Priest
(a) Residence. No. Twin Falls Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of David Priest

6. DATE OF BIRTH (month, day and year) June 6-1902

7. AGE Years 28 Months 1 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) France

PARENTS
10. NAME OF FATHER Julius Busy ~~George Waldman~~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France ~~Unknown~~
12. MAIDEN NAME OF MOTHER Anna Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Eli Priest
(Address) R.F.D. #1 Filer Ida

15. Filed August 6th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930 & July 29, 1930
that I last saw her alive on July 29, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows: Uterine hemorrhage
(duration) yrs. mos. 6 hours ds.
CONTRIBUTORY (Secondary) Incomplete abortion
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 7/29/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. D. Weaver M. D.
, 19 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Cemetery — Date of Burial 8-1 1930

20. Undertaker White Mortuary Inc — Address Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED AUG 14 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71522

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of County Hospital

Registration District No. 39

Primary Registration District No. 2087

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Jane Hyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 3 (Day) 1866 (Year)

7. AGE: 66 Yrs. 4 Mos. X ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: F. J. Brown

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Elizabeth Baker

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W. B. Hughes

(Address) Buhl, Ida.

15. Filed July 5 1930

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

48 (B)

16. DATE OF DEATH: July (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1930, to ..... 19..., that I last saw her alive on June 2 1930, and that death occurred on the date stated above, at 12 15 AM.

The CAUSE OF DEATH* was as follows:

Myocarditis (several years) post operative for cholecystitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Picks chirosis, cholecystitis chron. nephritis

(Duration) 5(?) yrs. ..... mos. ..... ds.

(Signed) E. L. Berry M. D.

7-3 1930 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 wk. ~~days~~. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida.

DATE OF BURIAL: July 6 1930

20. UNDERTAKER: L. Johnson

ADDRESS: Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STATE OF IDAHO

RECEIVED AUG 14 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71523

PLACE OF DEATH

County of Twin Falls

City of Twin Falls Co Hospital

Registration District No. 39

Primary Registration District No. 2087 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. **FULL NAME** Not Named (Baby Tyler)

(a) Residence. No. ..... Burley Ida. St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 30 min.
	✓	✓	✓	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Twin Falls County Hospital

PARENTS

10. NAME OF FATHER J. E. Tyler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Watertown S. D.

12. MAIDEN NAME OF MOTHER Beth Fletcher

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Casper Wyo.

14. Informant (Address) J. E. Tyler Burley Ida.

15. Filed 7-7 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~July~~ July 6, 1930, to July 7, 1930
that I last saw him alive on July 7, 1930
and that death occurred, on the date stated above, at 4 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature Birth
(8 mo)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pyelitis w Nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) J. H. Murphy M. D.

July 7 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	7/7 1930
20. Undertaker L. L. Johnson	Address Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED AUG 14 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7152

PLACE OF DEATH

County of Twin Falls

City of Twin Falls Co. Hospital

Registration District No. 34

Primary Registration District No. 2087 Local Registrar's No. .....

(No. 6 (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Margaret Emma Weaver

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 5½ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

74A

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of D. C. Weaver

6. DATE OF BIRTH (month, day and year) Sept 8-1867

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	10		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10. NAME OF FATHER Hiram Bennett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penna

12. MAIDEN NAME OF MOTHER Mary Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penna

14. Informant Pauline Weaver
(Address) Buhl Ida

15. Filed 7-10, 1930. J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17, 1930, to July 8, 1930, that I last saw her alive on July 8, 1930, and that death occurred, on the date stated above, at 7.20 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of June 17 1930
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) J. H. Murphy M. D.
7-10, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida — Date of Burial 7-10 1930

20. Undertaker L. D. Johnson — Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED AUG 14 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7157

PLACE OF DEATH

County of Lair Lake

City of Burke.

Registration District No. 39

Primary Registration District No. 2087 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

K9

2. **FULL NAME** McNellard Reed.

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 27 - 1918

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burke Ida.

PARENTS

10. NAME OF FATHER W. E. Reed.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Thelma Lawrence

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tennessee.

14. Informant (Address) W. E. Reed Burke, Ida.

15. Filed 7-10, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/9, 1930, to 7/9, 1930, that I last saw h~~im~~ alive on 7/9, 1930, and that death occurred, on the date stated above, at 10 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Fractured skull -
Dragged by a runaway horse.
Killed instantly
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? ✓

(Signed) Ke Jennings, M. D.
7/10, 1930 (Address) Burke, Ida.

19. Place of Burial, Cremation, or Removal: Burke Ida — Date of Burial: 7/10 1930

20. Undertaker L. L. Johnson — Address Burke Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71526

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 39
Primary Registration District No. 2087
(No. 480)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Wm. John Lewis

(a) Residence. No. Colby, Kans, Twin Falls Co Hospital - Colby, Kans.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Donna Lewis

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	9	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Taylorville Ill.

PARENTS
10. NAME OF FATHER Geo. Lewis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.
12. MAIDEN NAME OF MOTHER Elizabeth Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alton Ill.

14. Informant Donna Lewis
(Address) Colby - Kansas

15. Filed 7-10 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1930, to July 9 1930, that I last saw him alive on July 9 1930 and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 4 1930
Was there an autopsy? No.
What test confirmed diagnosis? Physical.

(Signed) J. H. Murphy, M. D.
7-10 1930 (Address) J. H. Murphy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal	Date of Burial 19
Colby Cemetery	
20. Undertaker Lulu Weatherly	Address Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 14 1930

DO NOT WRITE IN THIS SPACE
State File No. 7152?

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac Franklin Constant
(a) Residence. No. ..... Buhl Ida St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 20 yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Constant

6. DATE OF BIRTH (month, day and year) Oct 11 - 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	8	30	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work City Treasurer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Williamsville Ill.

PARENTS

10. NAME OF FATHER Avery Constant
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Louise Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant A. G. Constant
(Address) Oakland Calif.

15. Filed 7-12, 1930 J. T. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1930, to July 10, 1930
that I last saw he alive on July 10, 1930
and that death occurred, on the date stated above, at 8-15 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Staphylococcic - streptococcic meningitis (1 day) Pneumonia Lobular & acute media (3 mos)
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. L. Barry M. D.
July 12, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal: Buhl Ida — Date of Burial: 7/13 1930
20. Undertaker L. J. Chrisman — Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71528

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

90

2. FULL NAME James Albert Palmer

(a) Residence. No. 4½ miles St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Ella Estie Palmer

6. DATE OF BIRTH (month, day and year) Dec. 23, 1869

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	6	16	X

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming & stock
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Richard Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Nader
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs J A Palmer
(Address) Buhl, Idaho

15. Filed 7-14, 1930. J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7-9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-9, 1930, to 7/9, 1930
that I last saw him alive on 7/-9, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chron. Rheumatism
(duration) 5&6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Geo Jennings, M. D.
7-10, 1930 (Address) Buhl, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	7/14 1930.
20. Undertaker	Address
Lulu Weatherby	Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71529

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Co. Hospital

Registration District No. 39
Primary Registration District No. 2081
Local Registrar's No.
(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bethsheeba Tyler

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of J. E. Tyler

6. DATE OF BIRTH (month, day and year) Apr 14-1907

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	3		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER Willard Fletcher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Doris Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant J. E. Tyler Buhl
(Address)

15. Filed 7-16, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22, 1930, to July 14, 1930, that I last saw her alive on July 14, 1930, and that death occurred, on the date stated above, at 1 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia.

(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Pyuria
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No. What test confirmed diagnosis? Laboratory

(Signed) J. H. Murphy, M. D.
7-16, 1930 (Address) Buhl Ida.

19. Place of Burial, Cremation, or Removal Buhl Ida — Date of Burial 7/17 1930

20. Undertaker H. Johnson — Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71530

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 34
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ward Willis Merrell 1a

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 7 - 1923

7. AGE Years 6 Months 11 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl

PARENTS
10. NAME OF FATHER Ward Merrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Hazel Ray
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Washington

14. Informant (Address) Ward Merrell Buhl Ida.

15. Filed 7-16, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 15 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to July 15, 1930
that I last saw ~~him~~ alive on July 15, 1930
and that death occurred, on the date stated above, at 9 45 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hemorrhage into bowel (6 hrs)
Typhoid fever (12 days)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. L. Barry M.D.
7-16, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida. Date of Burial 7-18-1930

20. Undertaker L. J. Johnson Address Buhl Ida.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED AUG 14 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7152

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. **FULL NAME** Orson Lewis

(a) Residence. No. ..... Buhl, Ida. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced — —
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 26, 1911

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Guysville
(State or country) Ohio

PARENTS

10. NAME OF FATHER Valentine G. Lewis
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Guysville Ohio
12. MAIDEN NAME OF MOTHER Celia Dwyer
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Guysville Ohio

14. Informant Celia Lewis
(Address) Buhl, Ida.

15. Filed 7-15, 1930 J. F. Murfield Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 20 — July — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10, 1930, to July 20, 1930
that I last saw him alive on June 30, 1930
and that death occurred, on the date stated above, at 9:35 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Guysville, Ohio.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) E. L. Berry M.D.
July 21, 1930 (Address) Buhl Ida

19. Place of ~~Burial, Cremation,~~ or Removal	Date of Burial, 19
Guysville, Ohio	

20. Undertaker H. E. Evans — Address Buhl, Ida

RECEIVED AUG 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71532

PLACE OF DEATH

County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Rae Girdner

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	W.	X

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Nov. 26, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer X

9. BIRTHPLACE (city or town) (State or country) Nevada

PARENTS

10. NAME OF FATHER Geo. Girdner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Elma Marie Wasson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant C. T. Wasson
(Address) Buhl Idaho

15. Filed 7-28, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 23, 1930
that I last saw h- alive on July 23, 1930
and that death occurred, on the date stated above, at 9 20 p.m.
The CAUSE OF DEATH* was as follows:
Whooping cough

(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Jarbidge, Nev.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A. A. Norman, M. D.
July 24, 1930 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	July 25 1930
20. Undertaker	Address
Lyle S. Neatherly	Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 44
Primary Registration District No.
(No. ..... St.)

File No. 7153

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Midvale

If death occurs away from usual residence, give facts called for under special information.

RECEIVED AUG 12 1930

2. FULL NAME Lois Olivia Widner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
August (Month) 2 (Day) 1907 (Year)

7. AGE
22 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Washington

10. NAME OF FATHER: Frank E. Timpke.

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER: Mary E. Shaeffer.

13. BIRTHPLACE OF MOTHER
(State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank E. Timpke
(Address) Midvale Idaho.

15. Filed 8-9-'30 191....

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

117

16. DATE OF DEATH
July (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1930, to July 26 1930, that I last saw h.. alive on July 26 1930 and that death occured on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:
Operated Ruptured appendix.
Heart befor death
Premature birth on July 20 1930

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. A. Schmutz M. D.
July 29 1930 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale — DATE OF BURIAL: July 29 1930

20. UNDERTAKER: J. A. Anderson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Smith

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

71534

DO NOT WRITE IN THIS SPACE

State File No. 71534

Local Registrar's No. 70

107

2. FULL NAME EDWARD M. BAKER

(a) Residence. No. Box 224 (Usual place of abode) St. Glenns Ferry, Idaho (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. E. M. Baker

6. DATE OF BIRTH (month, day and year) Aug. 19, 1893

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	11	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Locomotive engineer

(b) General nature of industry, business, or establishment in which employed (or employer) xx

(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L. H. Beaman

(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 8-9, 1930 W. A. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to Aug. 9, 1930, that I last saw him alive on Aug. 9, 1930, and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis respiratory center

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock and tertiary syphilis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug. 8, 1930

Was there an autopsy? xx

What test confirmed diagnosis? Clinical

(Signed) F. S. SMITH, Reg.Med. Officer M. D.

8-9, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glen Rest Cemetery — Date of Burial: Aug. 12 1930

20. Undertaker: C. C. Zacher — Address: Glenns Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

715-35

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71535

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No.
(No.) St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number)

114

2. FULL NAME James Bob Burchfield
(a) Residence. No. Oxford Hotel St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb - 15 - 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Allie Tipton
(Address) Boise Idaho

15. Filed 8-16, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 14. (Month) 1930 (Day) (Year), 19....

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930, to Aug 14, 1930
that I last saw him alive on Aug 14, 1930
and that death occurred, on the date stated above, at 6.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P P French M. D.
Aug 15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hillcrest Cem	Aug 16 1930
20. Undertaker	Address
Dunnigan & Trefz	Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 25 1930

71536

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71536

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock
City of Pocatello.
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5825
(No. Pocatello Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

17a

2. **FULL NAME** Clyde. Curtis.

(a) Residence. No. Saratago. Wyo. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6. DATE OF BIRTH (month, day and year) May 28. 1898.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
32	3		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Edward Curtis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Sarah Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant W. E. Hearing.
(Address) Saratago Wyo.

15. Filed 8/14, 1930 J. P. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/12, 1930, to 8-12, 1930
that I last saw h~~e~~ alive on 8-12, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Crushed both legs in Pocatello
RR Yards- accidental
RR. accident
necessitating double amputation
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of 8/14-30
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. P. Young M. D.
8/14, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Saratago Wyo.	19
20. Undertaker H. L. McHan.	Address Poca. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

French

71537

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71537

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frederick. A. Heers. 128
(a) Residence. No. 1407. Jefferson Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Olive Heers.

6. DATE OF BIRTH (month, day and year) August. 23.1882.

7. AGE Years 47. Months 11 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago, Ill.

PARENTS

10. NAME OF FATHER Wilhelm Heers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant Mrs. Olive Heers.
(Address) 1407. Jefferson Street. Boise, Ida.

15. Filed 8-1, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930, to July 31, 1930
that I last saw him alive on July 28, 1930
and that death occurred, on the date stated above, at 6 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Nephritis and Asthma
(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French, M. D.
July 31, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Seward Nebraska
Date of Burial Aug. 2.1930.

20. Undertaker Summers & Krebs.
Address Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

PLACE OF DEATH

DEP[redacted]

DO NOT WRITE IN THIS SPACE

State File No. 71538

71538

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 33

(No. St. Maries Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin R Standiford

90

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs Standiford

6. DATE OF BIRTH (month, day and year) April 15 - 1890

7. AGE: Years 40, Months 4, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Forestry

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: U S Government

9. BIRTHPLACE (city or town) (State or country): Eaton Colo

PARENTS

10. NAME OF FATHER: Aquella Standiford

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Isa Shopaugh

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Mrs I Standiford

(Address): Polson Mont

15. Filed Sept. 6 1930 Bessie N Lepper State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1st June 16, 1930, to Sept 1, 1930

that I last saw him alive on Sept. 1st, 1930

and that death occurred, on the date stated above, at 7 45 A m.

The CAUSE OF DEATH* was as follows:

Coronary occlusion

..... (duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary): Endocarditis

..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D Cornwall, M. D.

Sept 1, 1930 (Address) St Maries

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida

Date of Burial: Sept 3 1930

20. Undertaker: Geo E Mitchell

Address: St Maries

RECEIVED SEP 11 1930

71542

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71542

PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 116

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Richard Randall

(a) Residence. No. 198 1/2 Saskatoon, Sask. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 22, 1910

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Saskatoon, Sask.

PARENTS

10. NAME OF FATHER Cecil Randall

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Kootenai Hospital
(Address) Coeur d Alene Ida

15. Filed 8/29, 1930 Harold J. Sturgo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1930, to Aug 16, 1930, that I last saw him alive on Aug 16, 1930, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:
Motorcycle Accident-
Severe Hemorrhage before being Found.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage & Shock.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Coeur d Alene
Did an operation precede death? Yes Date of Aug 16.
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) O L Boone M. D.
Aug 16, 1930 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Saskatoon, Can	
20. Undertaker	Address
Cassedy Funeral Home	Coeur d Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 9 1930

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

(No. U. S. Veterans' Bureau, Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

715-43

DO NOT WRITE IN THIS SPACE

State File No. 71543

Local Registrar's No. 75

90

2. FULL NAME Gus ODER

(a) Residence. No. Soldiers' Home, Boise, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. 18 How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6. DATE OF BIRTH (month, day and year) July 1, 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	1	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work --

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9. BIRTHPLACE (city or town) Ky.
(State or country)

PARENTS

10. NAME OF FATHER --

11. BIRTHPLACE OF FATHER (city or town) --
(State or Country)

12. MAIDEN NAME OF MOTHER --

13. BIRTHPLACE OF MOTHER (city or town) --
(State or Country)

14. Informant H. Bock

(Address) U. S. V. B., Boise, Idaho

15. Filed 9-2, 1930 W. W. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
July 12, 1930, to August 30, 1930
that I last saw h im alive on August 30, 1930
and that death occurred, on the date stated above, at 4:35 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency with de-
compensation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility and Nephritis
interstitial, chronic.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? --

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F. C. SMITH, Reg. Med. Off.

19 (Address) U.S.V.B., Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill	9/1 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. RECEIVED SEP 12 1930

71544

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 71544

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

CERTIFICATE OF DEATH

Registration District No. 65

Primary Registration District No. 2145.

(No. ..... St.)

1. PLACE OF DEATH

County of Latah.

City of Pottatch

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norman Balanger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: ✓ (Month) ✓ (Day) 1903 (Year)

7. AGE: 27 Yrs. ✓ Mos. ✓ ds. ✓

IF LESS than 1 day how many ✓ hrs. or ✓ min.? ✓

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow.

10. NAME OF FATHER: Balanger.

11. BIRTHPLACE OF FATHER (State or Country): France.

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (State or Country): Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Grant.

(Address) Clarkson. Wash.

15. Filed Aug. 18th 1930 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 17 (Day) 1930 (Year)

182

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19..., that I last saw h ✓ alive on ✓ 19..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

Whilst swimming

(Duration) ✓ Yrs. ..... mos. ✓ ds.

Contributory (Secondary)

(Duration) ✓ yrs. ..... mos. ✓ ds.

(Signed) J. W. Thompson M. D.

8/18/1930 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkson Wash.

DATE OF BURIAL: Aug 28th 1930

20. UNDERTAKER: merchant undertaking Co.

ADDRESS: Clarkson Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

715-45-

DO NOT WRITE IN THIS SPACE
State File No. 71545

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5878

101 B

2. FULL NAME Simon ~~Carega~~ (Carcaga)
(a) Residence. No. Bancroft Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Teodora Asqueta

6. DATE OF BIRTH (month, day and year): Mar. 25, 1893

7. AGE: 37 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheepman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Spain amoroto

PARENTS

10. NAME OF FATHER: Jose Maria ~~Jose Carega~~ (Carcaga)
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Vicenta Larreategui
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Rubio Landia
(Address): Pocatello Ida

15. Filed 8/12, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8/10 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-10, 1930, to 8-10, 1930
that I last saw him alive on 8-10, 1930
and that death occurred, on the date stated above, at 12 midnight
The CAUSE OF DEATH* was as follows:
Pneumococcic meningitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary): Lobar Pneumonia
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Bancroft
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
8/12, 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rupert Ida
Date of Burial: 8/13th 1930

20. Undertaker: Schumacher & Beasley
Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71516

PLACE OF DEATH

County of Ada
City of Orchard, Idaho

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 74
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME Dolores Gutierrez
(a) Residence. No. Orchard, Idaho. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 26th 1929

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Home, Idaho

PARENTS

10. NAME OF FATHER Pedro Gutierrez
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Erma Shields
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) Mrs. Pedro Gutierrez Orchard, Idaho.

15. Filed 8-27, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23rd 1930 (Month) (Day) 19.... (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19...., to ....., 19....
~~that I last saw h... alive on~~ ....., 19....
~~and that~~ death occurred, on the date stated above, at 5.05 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidently run into and over by Automobile, fracturing Skull. Death occured instantly.
(duration) ..... yrs. ..... mos. ..... ds.
No Inquest held.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed ~~diagnosis~~? .....
(Signed) W. McBrahey, Coroner, ~~M. D.~~
Aug 26, 1930 (Address) Boise, Idd

19. Place of Burial, Cremation, or Removal: Mountain Home, Idaho
Date of Burial: 8/25/30 19
20. Undertaker: G.C. Zacher
Address: MT. Home, IDa.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71547

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 73
(No. 189)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bernard Duncan Holman

(a) Residence. No. R.F.D. #3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 24, 1921

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	9	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None. At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meridian Idaho

PARENTS

10. NAME OF FATHER Wm J. Holman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Deweese Oregon
12. MAIDEN NAME OF MOTHER Velma Duncan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Parsonsburg Kansas

14. Informant W. D. Holman
(Address) Boise R.F.D. 3

15. Filed 8-26-30 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 21, 1930, to Aug 23, 1930
that I last saw h alive on 19
and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:
(1) Traumatic Rupture of Spleen - Kicked by horse
(2) Intra abdominal Hemorrhage
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Traumatic Shock
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Eagle Idaho
Did an operation precede death? Yes Date of Aug 22-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) Hamer H. Stewart, M. D.
Aug 26, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill	8-26 1930
20. Undertaker B. W. Robison	Address Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Bernard D. Holman

now lying buried in Morris Hill Cemetery, in the City or Town of Boise

County of Ada State of Idaho, who died on the 23rd day of Aug., 1930, Aged 8 years ____ months

____ days, the cause of death being Traumatic rupture of spleen and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Stewart attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private conveyor
private or railway conveyance

to Dry Creek Cemetery in the City or Town of Boise County of Ada

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Ada it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 14th day of July, A.D. 19 77.

Permit issued to:

Summers Funeral Home

Boise, Idaho

Janet M. Wick

by Joyce B. Foltz Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____

Health Officer

FORM BH 56-019

RECEIVED SEP 9 1930

~~RECEIVED SEP 9 1930~~

PLACE OF DEATH

County of Ada

City of Boise

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71548

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 72

(No. Taylor)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Matilda J. Nelson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: James Nelson

6. DATE OF BIRTH (month, day and year): May 23 - 1858

7. AGE: Years 72 | Months 2 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Clarinda Iowa

PARENTS

10. NAME OF FATHER: Wm Valentine

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: J. C. Nelson
(Address): Boise R. 4

15. Filed 8-19, 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 18th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2nd, 1930, to Aug. 18th, 1930

that I last saw her alive on Aug 15th, 1930

and that death occurred, on the date stated above, at 9:00 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - with (terminal condition) Arteriosclerosis and gangrene of foot (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus - (duration) 14 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine tests + Gangrene

(Signed) J. M. Taylor, M. D.

Aug 18th, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery | Date of Burial: Aug. 20 1930

20. Undertaker: W. S. Hateer | Address: Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71549

PLACE OF DEATH
County of Boise.
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 71

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Ingraham.

(a) Residence. No. Schaffer Creek, 20 Miles North of Boise
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank. P. Ingreham.

6. DATE OF BIRTH (month, day and year) May. 23.1872.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58.	2	21.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER John Ward.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Lydia Murray.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant Frank. P. Ingraham.
(Address) Horseshoe Bend, Idaho.

15. Filed 8-16, 1930. W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 14, 1930, that I last saw her alive on Aug 14, 1930 and that death occurred, on the date stated above, at 7 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Stomach poisoning
from Canned Oysters
Eaten raw.

(duration) yrs. mos. 12 hours

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. Freudell M. D.
Aug 15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Aug 16 1930
20. Undertaker: Summers & Krebs. — Address: Boise, Ida.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71550

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 69

(No. ¾ mile west of Collister)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. **FULL NAME** Mrs. Jane Bergh

(a) Residence. No. Collister-- West of Boise St.

(If nonresident give city or town and State.)

(Usual place of abode.)

Length of residence in city or town where death occured. 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of G. A. Bergh

6. DATE OF BIRTH (month, day and year) Feb. 7, 1857

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	5	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marshalltown. Iowa

PARENTS

10. NAME OF FATHER John Poyns.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.

12. MAIDEN NAME OF MOTHER Charlotte Pardee.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant Mrs. A. F. Van Voorhis.
(Address) Boise, Idaho

15. Filed 8-8, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August, 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3 or 3 minutes, 19..., to ..., 19...
that I last saw her alive on July 31, 1930
and that death occurred, on the date stated above, at 10:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Geo. Collins M. D.
..., 19... (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cemetery. Date of Burial: 8/8/30 19

20. Undertaker: W. McBratney Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71551

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 68
(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jack W. Watkins.
(a) Residence. No. Boise, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 41 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cleora Watkins.
6. DATE OF BIRTH (month, day and year): September 21st 1868
7. AGE: 61 Years, Months: 10, Days: 11. If LESS than 1 day, ~~hrs. or~~ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Superintendent Prison
(b) General nature of industry, business, or establishment in which employed (or employer): Farm. Boise, Idaho.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: I. H. Watkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: ------- Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Illinois

14. Informant (Address): Mrs. Cleora Watkins. Caldwell, Idaho.

15. Filed 8-8, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 2nd 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ----------, 19 , to ----------, 19 ~~that I last saw him alive on~~ ----------, 19 ~~and that~~ death occurred, on the date stated above, at ——— m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead in Bed.
Probably Cerebral Hemorrhage.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Natural Cause
No Inquest held. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of ——
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W McBratney Coroner, ~~M. D.~~
8/6/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Canyon Hill--Caldwell
Date of Burial: 8/8/30 19

20. Undertaker: W. McBratney
Address: Boise, Ida.

Mr Bratney

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71552

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 67
(No. Star, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Earl Summers.

(a) Residence. No. Star, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) December 2nd 1907

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
22	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Middleton, Idaho.

PARENTS

10. NAME OF FATHER Orin Summers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Ada Shaffer.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant Orin Summers.
(Address) Star, Idaho.

15. Filed 8 8 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 4th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---------- 19---- to ---------- 19----
that I last saw him alive on ---------- 19---- About 2:40 P.M
and that death occurred, on the date stated above, at ---- m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Struck by Lightning
Killed instantly
accidental

(duration) ---- yrs. ---- mos. ---- ds.

CONTRIBUTORY (Secondary) No Inquest held.

(duration) ---- yrs. ---- mos. ---- ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No. Date of ----
Was there an autopsy? No.
What test confirmed diagnosis? ----

(Signed) Wm. McBratney Coroner, M. D.
8/6/30, 19---- (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8/6/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7455

PLACE OF DEATH
County of Ada.
City of Meridian.

Registration District No. 8
Primary Registration District No. 2004
(No. Meridian, Idaho.)
Local Registrar's No. 66
168
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Lester Lewis.

(a) Residence. No. Meridian, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 41 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Clara Lewis

6. DATE OF BIRTH (month, day and year) January 29th 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	6	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER Wm. Lewis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Sarah Hilman.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant (Address) Wm. Lewis, Meridian, Idaho.

15. Filed 8-8, 19 30 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 4th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ and that death occurred, on the date stated above, at ~~m.~~

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Suicide by hanging himself by the neck.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~~None~~
Did an operation precede death? ~~None~~ Date of ~~None~~
Was there an autopsy? ~~No~~
What test confirmed diagnosis? ~~None~~
(Signed) Wm. McBratney, Coroner, M.D.
8/6/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Meridian Cemetery — Date of Burial: 8-10-30 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71554

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 65
(No. Boise, Idaho. Route #2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William B. Milks. 50
(a) Residence. No. Boise, Idaho R.#2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 9th 1866

7. AGE: 64 Years | Months: 3 | Days: 29 | If LESS than 1 day, ---------- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lawler, Iowa.

PARENTS

10. NAME OF FATHER: Humphry Milks.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Georgianna Poole.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): England.

14. Informant (Address): R. C. Milks, Boise, Idaho.

15. Filed 8-7, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 8th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-31, 1930, to 8-8, 1930
that I last saw him alive on 8-8-, 1930
and that death occurred, on the date stated above, at 4:15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Extremal Carcinoma on back —

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —

(Signed) H. F. Neal, M. D.
8/11/30, 1930 (Address) ~~Boise~~, Idaho. Meridian

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8/11/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

Genoway RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71555

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 64
(No. Owyhee ~~Collister~~ Station.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mrs. Clara Merrell Reed
(a) Residence. No. Owyhee ~~Collister~~ Station, Boise, Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Curtis H. Reed.

6. DATE OF BIRTH (month, day and year) October 21st 1873

7. AGE Years 56 Months 9 Days 14 If LESS than 1 day, ~~hrs. or~~ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lake City, Minn.

PARENTS
10. NAME OF FATHER Rhodes Merrell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Josephine Webster.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant (Address) Curtis H. Reed. ~~Boise, Idaho.~~

15. Filed 8-5, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 5th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929 to June 21, 1930
that I last saw her alive on June 21, 1930
and that death occurred, on the date stated above, at About 3 A.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Nephritis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) Chas F Genoway, M. D.
8/6/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 8-7-30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71556

PLACE OF DEATH
County of Ada
of Eagle

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 63
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Edward Bardwell. 1/2

(a) Residence. No. Star Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Pearl B. Bardwell

6. DATE OF BIRTH (month, day and year) Dec 19 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carney Missouri

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant Mrs Pearl B. Bardwell
(Address) Middleton Idaho

15. Filed 8-4, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 14, 1930, to July 31, 1930
that I last saw him alive on July 31, 1930
and that death occurred, on the date stated above, at 4.4 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Catarrhal duodenitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hepatic congestion *
excessive (duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. D. Anthony, D.C.
Aug. 2, 1930 (Address) 316 McCarty Bldg Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Aug 4 1930
20. Undertaker: Summers & Reed — Address: Boise Ida

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71557

PLACE OF DEATH
County of Ada.
City of Boise. Idaho.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 221
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Mrs Harriet L. Annett.
(a) Residence. No. I904 N. I6th Street. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 29-I847.

7. AGE Years 82 Months II Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bury England.

PARENTS
10. NAME OF FATHER John Richardson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Mary Pope.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bolton. England.

14. Informant (Address) Frank C. Annett. I904 N. I6th Street.

15. Filed 8-5, 1930 W K Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 5th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to Aug 5th, 1930
that I last saw her alive on Aug 3d, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Valvular Wart trouble and Emphysema — causing Dropsy —
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. H. McBrook, M. D.
Aug 6th, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery.
Date of Burial Aug. 6 1930

20. Undertaker Summers & Krebs.
Address Boise Idaho.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7155

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1008
Local Registrar's No. 220
(No.) St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rene Louis Daguerre

(a) Residence. No. ..... St. Oakland, Calif
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) April 8-1909

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	3	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Covington, La.

PARENTS

10. NAME OF FATHER John Daguerre
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER Josephine Larrazquette
13. BIRTHPLACE OF MOTHER (city or town) (State or County) France.

14. Informant (Address) Justin Daguerre 62-39 st Oakland

15. Filed 8-5, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 4 - 1930
that I last saw him alive on Aug 4, 1930
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebro-Spinal Meningitis

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cerebro-Spinal Menin.
(duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? Pocatello, Idaho.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Lab.
(Signed) Donald T. Hokes M. D.
Aug 5 1930 (Address) Eastman Bldg

19. Place of Burial, Cremation, or Removal: Oakland, Calif — Date of Burial: 8-6 1930
20. Undertaker: Schreiber & McCann — Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1550

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 219
(No. 1903 Resseguie St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Henry Leimberger.

(a) Residence. No. 1903 Resseguie St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna B. Leimberger.

6. DATE OF BIRTH (month, day and year) April 2nd 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	4	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Union Hill, N. J.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austria.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant (Address) John S. Gasser. Boise, Idaho.

15. Filed 8-5, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 3rd 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from ....., 19..., to ....., 19...
that I last saw him alive on ....., 19... and that death occurred, on the date stated above, at 5:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis -
8 (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cystitis
/ (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
8/4/30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	8/5/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7156

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 218
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159e

2. FULL NAME Shirley Mae Snow.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) August 2nd 1930

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or
0	0	0	45 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Joe Snow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Berryville, Ark.
12. MAIDEN NAME OF MOTHER Maybelle Fisher.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Eagle, Idaho.

14. Informant (Address) Joe Snow. Eagle, Idaho.

15. Filed 8-4, 19.... W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 2nd 1930, 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1930, to Aug 2nd, 1930
that I last saw her alive on Aug 2nd, 1930
and that death occurred, on the date stated above, at 12:58 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
complete atelectasis - feeble heart beat - cord - green yellowish - no pulsation - lived 45 minutes only - (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) obstruction in circulation of cord (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bouk, M. D.
8/4/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial 8/3/30, 19

20. Undertaker: Wm. McBratney. — Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71561

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 217
(No. 6t Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Rosella Mae Kelso 41

(a) Residence. No. Oxford Hotel St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10-6-1881

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	9	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Proprietress
(b) General nature of industry, business, or establishment in which employed (or employer) Restrant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lodi, Wis.

PARENTS

10. NAME OF FATHER J. I. Newcomb
11. BIRTHPLACE OF FATHER (city or town) (State or Country) USA
12. MAIDEN NAME OF MOTHER Dalferna Chrystler
13. BIRTHPLACE OF MOTHER (city or town) (State or County) USA.

14. Informant (Address) Ira Kelso Salem, Ore.

15. Filed 8-2, 1930 W. W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, to Aug 1, 1930, that I last saw her alive on July 31, 1930, and that death occurred, on the date stated above, at 4 15 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Staphylococcus Bacteremia

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 5/15/30
Was there an autopsy? yes Blood cultures
What test confirmed diagnosis?
(Signed) H. E. Bridgman M. D.
Aug. 1, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial 8-2-30
20. Undertaker: Schreuder & McCann — Address Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED SEP 9 1930

DO NOT WRITE IN THIS SPACE

State File No. 7153

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 216

(No. Idaho Soldiers Home Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Bower. 79

(a) Residence. No. Idaho Soldiers Home. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August. 2.1844.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
85.	11	29.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER Benjamin Bower.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant (Address) John. W. Leonard. 605. Hays Street, Boise, Idaho.

15. Filed 8-2, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 1 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/1, 1930 to 8/2, 1930 that I last saw him alive on 7/26, 1930 and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Coronary Heart Disease.

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical Symptoms

(Signed) Fred A Pilkington, M. D.

8/2, 1930 (Address) Boise Id

19. Place of Burial, Cremation, or Removal	Date of Burial
Pioneer Cemetery.	Aug. 2. 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Bock

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71503

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 214

(No. St Lukes Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** William Charles Annett.

(a) Residence. No. 2314. Woodlawn Ave. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 4. 1851.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	5	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boston Mass.

PARENTS

10. NAME OF FATHER William Annett.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Mary Watkins.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant Charles. L. Annett.
(Address) Kuna, Idaho.

15. Filed Aug 1, 30 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 31, 1930
that I last saw h[illegible] alive on July 30, 1930
and that death occurred, on the date stated above, at 6.30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis & prostatis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. W. Bock, M.D.

July 31, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Aug. 1. 1930

20. Undertaker: Summers & Krebs. Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 1150

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 213

(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

172 E

2. **FULL NAME** Charles E. Baker.

(a) Residence. No. 510 South 14th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Arzola Baker.

6. DATE OF BIRTH (month, day and year) April 2nd 1871

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
59	3	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Jacob Baker.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Don't Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Chas. Hardin.
(Address) Boise, Idaho.

15. Filed 8-1, 1930 W.W. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to July 30, 1930
that I last saw him alive on July 30, 1930
and that death occurred, on the date stated above, at 3:20 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Fracture of Base of skull
Auto accident

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of July 29, 1930
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Harold W. Stone, M. D.
7/31/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	8/2/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71565

PLACE OF DEATH

County of Ada

City of

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 235

(No. St Alphonsos Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Paul Buehler

(a) Residence. No. Ada County Hospital St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) about 1872

7. AGE 58 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ulm Germany

PARENTS

10. NAME OF FATHER Not obtainable

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) N. F. Mussmann Boise Idaho

15. Filed 8-30, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1930, to Aug. 29, 1930

that I last saw him alive on Aug. 29, 1930

and that death occurred, on the date stated above, at 3-15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage left side.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Advanced arteriosclerosis

Hemorrage about (duration) 10 ago yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Finding at autopsy

(Signed) Chas. R. Lowe, M. D.

Aug. 29, 1930 215 (Address) First Nat Bank Boise, Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 8/30 1930

20. Undertaker Schreiber & McCann Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7150

PLACE OF DEATH

County of Ada.
City of Boise Idaho.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 234

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Ashley N. Gibson.

(a) Residence. No. 504 South 14th Street. St.
(Usual place of abode.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Mildred L. Gibson

6. DATE OF BIRTH (month, day and year) June-6-1889.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Whole Sale House.
(c) Name of employer Falk Co. Boise Idaho.

9. BIRTHPLACE (city or town) (State or country) Springfield Mo.

PARENTS

10. NAME OF FATHER John Gibson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) Mildred L. Gibson.

15. Filed 8-26, 1930 W. E. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 24 2 p.m. 30, to aug 24 5:15 PM 30
that I last saw him alive on aug 24, 19 30
and that death occurred, on the date stated above, at 5:15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

accidental following auto accident instant over steep grade, Shock (Traumatic)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Internal Injuries and Hemorrhage
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Findings
(Signed) G. A. Wylie, M. D.
aug 26, 19 30 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Aug. 27 19 30
20. Undertaker: Summers & Krebs	Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71567

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 233

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** James Francis Heavren

(a) Residence. No. Portland, Oregon St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Adelia Heavren

6. DATE OF BIRTH (month, day and year) February, 9, 1858

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	6	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Merchandising
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairhaven, Conn.

PARENTS

10. NAME OF FATHER Patrick Heavren

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Mrs. L. J. Breslin, Boise, Idaho

15. Filed 8-25, 1930 W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August, 24, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14th, 1930 to Aug 24th, 1930 that I last saw him alive on Aug 23rd, 1930 and that death occurred, on the date stated above, at 4: A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebrum of Stomach

(duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

8/25/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: St. John's Cemetery — Date of Burial: 8/26/30 19

20. Undertaker: W. McBratney — Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7450

PLACE OF DEATH
County of Ada.
City of Boise Idaho.

Registration District No. 2
Primary Registration District No. 1002
Local Registrar's No. 232
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Sam Glenn.

(a) Residence. No. 317½ North 8th Street. St. 126
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 52 years.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Forest Ranger.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) James Oconnor. Eagle Lodge Boise Idaho.

15. Filed 8-25, 1930. W. R. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 23 (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1930, to Aug 23, 1930, that I last saw him alive on Aug 23, 1930, and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Peritonitis

(duration) yrs. mos. 7 da.
CONTRIBUTORY (Secondary) Perforation of gastric ulcer
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P P French M. D.
Aug 25, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Aug 25 1930

20. Undertaker: Summers & Krebs Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7150

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 231
(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Hattie F. Noble

(a) Residence. No. 920 Hayes. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 3½ yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W.	Widow

5a. If married, widowed, or divorced.
~~HUSBAND of~~ ~~(or)~~ WIFE of Wm B. Noble, Deceased

6. DATE OF BIRTH (month, day and year) Dec 12-1848

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Columbus City Iowa.

PARENTS

10. NAME OF FATHER Joseph A. Luckett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Mariah Gore
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Md.

14. Informant (Address)

15. Filed 8-23, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/12, 1930 to 8/21, 1930
that I last saw her alive on 8-21, 1930
and that death occurred, on the date stated above, at 6 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) Attorney, M. D.
8/22/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8/23/30 #19
20. Undertaker: D McBratney Address: Boise Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1150

PLACE OF DEATH
County of Ada.
City of Boise Idaho.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 220

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George W. Brookover. 50

(a) Residence. No. 1716 N.-9th Street St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May-12-1845.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Adams County
(State or country) Ohio.

PARENTS

10. NAME OF FATHER John Brookover.

11. BIRTHPLACE OF FATHER (city or town) Adams County
(State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Eliza Grimes

13. BIRTHPLACE OF MOTHER (city or town) Adams Co.
(State or County) Ohio.

14. Informant S. E. Brookover.
(Address) Boise Idaho.

15. Filed 8-20, 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 9, 1930, to Aug 19, 1930
that I last saw him alive on Aug 18, 1930
and that death occurred, on the date stated above, at 2 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Abdominal tumor
probably on the Colon.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Senility (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms

(Signed) J. Reno Numbers M. D.
Aug 19, 1930 (Address) Boise Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Carrollton Missouri.	Aug.-24-1930,
20. Undertaker	Address
Summers & Krebs.	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 715[illegible]

PLACE OF DEATH
County of Ida
City of Boise

Registration District No. 2
Primary Registration District No. 1[illegible]
Local Registrar's No. 229
(No. St Alophonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Joseph Jones 90
(a) Residence. No. 818 N 10 St St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Winifred Cullen Jones

6. DATE OF BIRTH (month, day and year) Nov 18 1858

7. AGE 72 Years | Months 8 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work attorney
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scranton Penn

PARENTS
10. NAME OF FATHER David Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Ann Powell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Naughton Wales

14. Informant (Address) Thos J Jones Jr 818 N 10 St Boise

15. Filed 8-18, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Aug 14, 1930
that I last saw him alive on Aug 13, 1930
and that death occurred, on the date stated above, at 6:45 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) Chas. P. Gennoy, M. D.
, 19.... (Address) Boise

19. Place of Burial, Cremation, or Removal St Johns Cemetry | Date of Burial 8-17 1930

20. Undertaker Schreiber & McCann | Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 715[illegible]

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 228
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Martin Golse
(a) Residence. No. 416 Bannock St. Boise.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth 1[illegible] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Golse

6. DATE OF BIRTH (month, day and year) Nov. 9 1894

7. AGE 35 Years 35 Months 9 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laboras
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Boise Payette Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Juev Slavia

PARENTS

10. NAME OF FATHER John Golse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Juev Slavia
12. MAIDEN NAME OF MOTHER Katherine Mikalesich
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Juev Slavia

14. Informant (Address) Mike Miller

15. Filed 8-18, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Aug 18, 1930
that I last saw him alive on Aug 17, 1930
and that death occurred, on the date stated above, at 2 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of mediastinal, secondary to carcinoma of lip.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pressure on wind pipe
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J S Springer, M. D.
8/18, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal St. John's Cemetery Date of Burial 8/20 1930

20. Undertaker Schreiber & Wm. Cann Address Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71523

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 227
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Bailey 90
(a) Residence. No. 405 Myrtle St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Marie J. Bailey

6. DATE OF BIRTH (month, day and year) 1865 - Jan 25

7. AGE ~~65~~ Years 65 Months 6 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Restaurant Owner
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) State of New York

PARENTS
10. NAME OF FATHER Alvin Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) State of New York
12. MAIDEN NAME OF MOTHER Marie Jeannette Sinnett
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Alvin G. Bailey 533 N. 72nd St. Seattle Wash.

15. Filed 8-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 12th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1930, to Aug 12th, 1930
that I last saw him alive on Aug. 12th, 1930
and that death occurred, on the date stated above, at 2:15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dilatation of heart - accompanied with valvular heart lesions & hypertrophy (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Kidney trouble - stone in pelvis of kidney (duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bach M. D.
Aug 14th 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetry
Date of Burial 8-15 1930

20. Undertaker Schreiber McClain
Address Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 715

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boise Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 226
(No. 60)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Estelle Blake Yarington

(a) Residence. No. 701 Grove St. Boise, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov. 15 - 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	67	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer City of Boise

9. BIRTHPLACE (city or town) (State or country) Wilkesbarre, Pa.

PARENTS

10. NAME OF FATHER Yarington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S. A.
12. MAIDEN NAME OF MOTHER Caroline A. Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wilkesbarre, Pa.

14. Informant Mary R. Baldwin
(Address) 701 Grove St Boise Ida

15. Filed 8-18, 1930 U. K. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 16, 1930
that I last saw h.. alive on Aug 16, 1930
and that death occurred, on the date stated above, at 2 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral insufficiency
acute dilatation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) A. H. Parker, M. D.
Aug 16, 1930 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal: Pioneer Cemetery — Date of Burial: 8-17 1930

20. Undertaker: Schreiber McLaren — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71575

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 224
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. **FULL NAME** Hannibal Douglas Goodman.

(a) Residence. No. One Mile west of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Dora Goodman.

6. DATE OF BIRTH (month, day and year) January. 6. 1858.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72.	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coles County Illinois.

PARENTS

10. NAME OF FATHER George. W. Goodman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant Mrs. H.D. Goodman.
(Address) R.D.#. 2. Boise, Idaho.

15. Filed 8-11, 1930 W.P. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to Aug 10, 1930
that I last saw him alive on Aug 10, 1930
and that death occurred, on the date stated above, at 100 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septicaemia Secondary
Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Abscess of left kidney
(Stated). (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Boise Ida
Did an operation precede death? Yes Date of July 23
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) James L. Howorth, M. D.
Aug 11, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery, — Date of Burial: Aug. 13. 1930

20. Undertaker: Summers & Krebs. — Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Boeck

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7157

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 223
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Sylvester N. Hickman.

(a) Residence. No. 2226 State St. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 18 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Henrietta Hickman.

6. DATE OF BIRTH (month, day and year) July 22nd 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	0	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Lumberman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newton, Iowa.

PARENTS

10. NAME OF FATHER John Hickman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know.
12. MAIDEN NAME OF MOTHER Martha Adams.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know.

14. Informant Roy Leonardson.
(Address) Boise, Idaho.

15. Filed 8-11 19 30 W.A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 7th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31st 30 to Aug 7th 30
that I last saw him alive on Aug 7th 30
and that death occurred, on the date stated above, at 10:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Uraemic poisoning
following
Prostatic Cong
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Enlarged Myocardium
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Burke M. D.
8/8/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 8-11-30

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1152

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 222
(No.) St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Marohn
(a) Residence. No. Marohn St. Valley County
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER a a
11. BIRTHPLACE OF FATHER (city or town) (State or Country) a a
12. MAIDEN NAME OF MOTHER a a
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) a a

14. Informant (Address) A. Schreiber Boise Idaho

15. Filed 4-9-30 C. F. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Aug 8, 1930, that I last saw him alive on Aug 7, 1930, and that death occurred, on the date stated above, at 4 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
THE CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. Several weeks

18. Where was disease contracted if not at place of death? done
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Labo.
(Signed) Gerald T. Nokes M. D.
Aug 9, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery, Boundary Plat — Date of Burial: 8/11/1930
20. Undertaker: Schreiber & McCaus — Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Ada
City of Star

Registration District No. 9+10
Primary Registration District No. 9+10 Local Registrar's No. 9
(No. 163)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Edith Hunt.

(a) Residence. No. Star, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. — mos. 29 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug - 3 - 1929.

7. AGE: Years 1 | Months — | Days 29 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Star Idaho

PARENTS

10. NAME OF FATHER: Wm Hunt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Jackson Co, Kan
12. MAIDEN NAME OF MOTHER: Agnes Ellison Myrtle Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Star

14. Informant (Address): Wm Hunt Star, Ida

15. Filed 4-1, 1930 Orville Jackson Registrar. Eagle Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 1 (Month) (Day) 1930. (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ [illegible], 19..., to [illegible], 19...
~~that I last saw h~~ [illegible], alive on [illegible], 19...
~~and that~~ death occurred, on the date stated above, at about 5 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Probably Inanition.
No Medical Doctor in attendance
for several days. Had been
sick for (duration) 1 yrs. Days mos. ds.
CONTRIBUTORY (Secondary) Natural Cause.
No Inquest held.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of [illegible]
Was there an autopsy? No.
What test confirmed diagnosis? [illegible]
(Signed) W McBratney Coroner M.D.
9-2-30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Star Cemetery — Date of Burial: 9-2-30 19
20. Undertaker: W McBratney — Address: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1930

PLACE OF DEATH

County of Adams

City of New Meadows

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 71

Primary Registration District No.

(No. Death occurred at his home)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71579

Local Registrar's No.

66

2. FULL NAME John Devers,

(a) Residence. No. New Meadows, Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White, American	Married

5a. If married, widowed, or divorced — HUSBAND of ~~(or) WIFE of~~ Mrs. A. Swift Devers,

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	—	—	

8. OCCUPATION OF DECEASED Laborer,

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Works for self at odd jobs,

9. BIRTHPLACE (city or town) (State or country) Narrows, Kentucky

PARENTS

10. NAME OF FATHER Clarence Devers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Blake Hancock,

(Address) New Meadows, Idaho

15. Filed Sept. 8, 1930 W. M. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 23, 1930, to August 23, 1930 that I last saw him alive on August 23, 1930 and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism,

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Delirium Tremens,

(duration) — yrs. — mos. 10 ds.

18. Where was disease contracted if not at place of death? At his home

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Self evident,

(Signed) W. N. Schuyler, M. D.

Aug. 24, 1930 (Address) New Meadows,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Meadows Ida	Aug. 24 1930
20. Undertaker	Address
A. A. Chilcoton	New Meadows

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71581

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. East Yards O.S.L.R.R.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5881

174

2. FULL NAME Cornelious Austin French

(a) Residence. No. 409 North 8th. Ave. Poca., Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Husband of Etta DeWitt

6. DATE OF BIRTH (month, day and year): September 3, 1869.

7. AGE: Years 60, Months 11, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Foreman

(c) Name of employer: O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS

10. NAME OF FATHER: George French

11. BIRTHPLACE OF FATHER (city or town) (State or Country):

12. MAIDEN NAME OF MOTHER: Elina Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs. Etta French
(Address) 409 North 8th. Ave. Poca., Ida.

15. Filed 8/15/30., 19.. J. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 13, (Day) 1930. (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from ....., 19.., to ....., 19..

that I last saw h..... alive on ....., 19..

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Head severed from body run ~~of~~ over by freight car O.S.L. yards. (Suicidal)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur W. Hall Coroner, ~~M.D.~~

8/14/30., 19.. (Address) Poca., Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. Date of Burial: 8/17/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71589

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5880

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 656 W Lewis)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Thomas Ewing Harris

(a) Residence. No. 656 W Lewis St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 8th 1836

7. AGE — Years: 94 — Months: — — Days: 5 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Funeral Director
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Columbus Ohio

PARENTS

10. NAME OF FATHER: Nathaniel Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: I H Masters
(Address): Pocatello Idaho

15. Filed 9-14 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 13th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24, 1930, to Aug 13, 1930
that I last saw h[illegible] alive on 8-13, 1930
and that death occurred, on the date stated above, at 11 45 A.M.
The CAUSE OF DEATH* was as follows: Senility Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D C Ray, M. D.
9-14-30 1930 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salt Lake City Utah — Date of Burial: 8-30 1930
20. Undertaker: Schumacher & Beasley — Address: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7159

PLACE OF DEATH
County of Bannock
City of McCammon

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 3829

(No. Residence McCammon, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjamin Turner Rowe

(a) Residence. No. McCammon, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

44

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Jane Allen

6. DATE OF BIRTH (month, day and year) January 15, 1863.

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	6	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Benjamin T. Rowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Rebecca Ann Pope
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Mrs. Benjamin T. Rowe
(Address) McCammon, Idaho.

15. Filed 8/11/30., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 10, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-22-, 1930, to 7-2-, 1930
that I last saw h— alive on 7-2-, 1930
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Carcinoma of liver
(duration) ....yrs. 3 mos. ....ds.
CONTRIBUTORY (Secondary) Diagnosed by Dr Hall Pocatello
Carcinoma of liver
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) Arthur D. Hall, M. D.
8/11/30., 19.... (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
McCammon, Idaho.	8/13/30.19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71584

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. Lynn Brothers Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5877

2. FULL NAME James Henry Nussbaum

(a) Residence. No. 758 North Seventh Ave. Poca., St.
(Usual place of abode)

156

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Febuary 12, 1922.

7. AGE

Years	Months	Days	If LESS than 1 day,
8	5	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Montpelier, Idaho.

PARENTS

10. NAME OF FATHER: John J. Nussbaum

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Emily Anderegg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: John J. Nussbaum

(Address) 758 North Seventh Ave. Poca., Ida.

15. Filed 8/9/30., 19__ J. L. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 9, (Day) 1930. (Year) 19__

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 9, 1930

that I last saw him alive on Aug 9, 1930

and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows: General peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured appendix History (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug-8-30

Was there an autopsy? no

What test confirmed diagnosis? Exam & operation

(Signed) J. L. Young, M. D.

8/30/30., 19__ (Address) Poca, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier, Idaho. Date of Burial: 8/12/30. 19__

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED SEP 10 1930

DO NOT WRITE IN THIS SPACE
State File No. 71586

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5896
(No. County Infirmary
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arthur Briggs

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years 72 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County)

14. Informant (Address) Glenn Briggs 1112 Maiden Lane

15. Filed Sept 2, 1930. Pullman Wash J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 2 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1929, to Sept 2, 1930
that I last saw him alive on Sept 1, 1930
and that death occurred, on the date stated above, at 12 30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. R. Young M. D.
9-2, 1930 (Address) County

19. Place of Burial, Cremation, or Removal Pocatello Ida | Date of Burial Sept 3 1930

20. Undertaker McHandt B. Poca | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Bannock
City of Downey

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. [illegible]
(No. On Highway 3 Miles North of Downey
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fanny Elizabeth Hammons
(a) Residence. No. Oark, Arkansas. St. Oark, Arkansas.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Gus Hammons

6. DATE OF BIRTH (month, day and year) May 31, 1896.

7. AGE: Years 34, Months 3, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER: John L. Whitmire
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Georgia.
12. MAIDEN NAME OF MOTHER: Mathilda Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Arkansas

14. Informant (Address): Mrs. McKinley Easteppe, Kuna, Idaho.

15. Filed 9/4/30., 19.. Dr. J. K. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 1, (Day) 1930. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Basal Skull Fracture
Car Accident on Highway North of Downey, Idaho.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Killed Instantly
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W. Hall Coroner M. D.
9/3/30., 19.. (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Jerome, Idaho. Date of Burial: On Arrival 19

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. [illegible]
Primary Registration District No. [illegible] Local Registrar's No. [illegible]
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

184 C

2. FULL NAME Audrey H. Edwards
(a) Residence. No. Oark, Arkansas. St. Oark, Arkansas.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 17, 1918.

7. AGE Years 12 Months 1 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER Thomas W. Edwards
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Fanny Elizabeth Whitmire
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Arkansas

14. Informant (Address) Mrs. McKinley Easteppe Kuna, Idaho.

15. Filed 9/4/30., 19.... D. J. K. Young Registrar. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 1, 1930., 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fractured Skull, Spine, & Legs.
Car Accident on Highway North of Downey, Idaho. Lived 7 Hours
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Arthur W. Hall Coroner M. D.
9/3/30., 19.... (Address) Pocatello, Ida

19. Place of Burial, Cremation, or Removal Jerome, Idaho. Date of Burial On Arrival

20. Undertaker Arthur W. Hall Address Pocatello

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71589

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5893

(No. Lynn Brothers Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Martha Ann Madsen

(a) Residence. No. 440 South Grant Ave. Poca., Ida. St. Driggs, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 2 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of Christian E. Madsen

6. DATE OF BIRTH (month, day and year): January 1, 1878.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	7	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS

10. NAME OF FATHER: John Daniels

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Margaret Morris

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Christian E. Madsen
(Address) Driggs, Idaho.

15. Filed 8/30/30., 19__ J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 29, (Day) 1930. (Year) 19__

17. I HEREBY CERTIFY, That I attended deceased from 5/30/30 19__, to 8/29/30 19__ that I last saw her alive on May 29, 1930 and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 6 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of June 5-1930

Was there an autopsy? no

What test confirmed diagnosis? Phy. Examinations

(Signed) J. W. Lynn, M. D.

8/29/30., 19__ (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan, Utah. Date of Burial: 8/31/30. 19__

20. Undertaker: Arthur W. Hall Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7159

Registration District No. 28

Primary Registration District No. 216

Local Registrar's No. 5892

(No.) Lynn Bros Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna DeGiulio

(a) Residence. No. Pingree Idaho

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Giustino DeGiulio

6. DATE OF BIRTH (month, day and year): Nov 11 1881

7. AGE: Years 48 | Months 9 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10. NAME OF FATHER: Joseph Rossi

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Angelantonio Carinci

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy

14. Informant: Giustino DeGiulio

(Address) Pingree Idaho

15. Filed 9-1-, 19 30 Dr J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Sept 1, 1930, that I last saw her alive on Sept 1, 1930, and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Post Dephtheritic paralysis

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Dephtheritis

(duration) yrs. 1 mos. 14 ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) J R Young, M. D.

9/5/30 19 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Cem | Date of Burial: Sept 3 1930

20. Undertaker: Schumacher Mortuary | Address: City

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7159

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 5891

100a

2. FULL NAME Patricia Louise Pugmire

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16, 1929.

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	2	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer At Home

9. BIRTHPLACE (city or town) (State or country) Portland, Oregon.

PARENTS

10. NAME OF FATHER William G. Pugmire
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bennington, Idaho.
12. MAIDEN NAME OF MOTHER Lillian June Holwagner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oaklahoma.

14. Informant Mrs. William G. Pugmire
(Address) Soda Springs, Idaho.

15. Filed 8/28/30. 19 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 27, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-22, 1930, to 8-27, 1930
that I last saw her alive on 8-27, 1930
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia -
both Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY - (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No. Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. H. Young M. D.
8/28/30. 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	8/29/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1930

PLACE OF DEATH

County of Bannock

City of Pocatello

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No. In Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 71502

Local Registrar's No. 5890

49 (B)

2. FULL NAME John Whalen

(a) Residence No. ..... St. .....
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 19th 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	5	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired R R Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Thomas Whalen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Whalen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant W B Whalen

(Address) Boise Idaho

15. Filed 8/29, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/1, 1930, to 8/20, 1930

that I last saw him alive on 8/25, 1930

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Injury to head - fell from truck 8-1-30 - Pocatello city.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Young M. D.

8/29, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	8/31 1930

20. Undertaker	Address
Schumacher & Beasley	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7151

PLACE OF DEATH

County of Bannock
City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5889
(No. Poc. Gen Hosp.)
(If death occurred in a hospital or institution, ~~give its name~~ instead of street and number.)

2. FULL NAME John ~~[illegible]~~ Peterson
(a) Residence. No. 127, So. 15 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 14-1861

7. AGE: Years 70 Months 9 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer &
(b) General nature of industry, business, or establishment in which employed (or employer): farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Nels Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Sweden

14. Informant (Address): E. A. Ohman

15. Filed Aug 25 1930 J. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/21, 1930, to 8-24, 1930
that I last saw him alive on 8/24, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. Young M. D.
8/25, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello Ida
Date of Burial: Aug 26 1930

20. Undertaker: McHan Undt Co. Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71595

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

Local Registrar's No. 5887

(No. Tie Plant, North of Poca., City.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Eugene Milligan

90

(a) Residence. No. Pocatello, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 20, 1930.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	One	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Byron Milligan

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Payson, Utah.

12. MAIDEN NAME OF MOTHER: Constance Pugmire

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Montpelier, Idaho.

14. Informant: Byron Milligan
(Address) Tie Plant, North of Poca., City

15. Filed 8/23/30., 19 J. A. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 21, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 21, 1930

that I last saw him alive on Aug 21, 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Probably valvular trouble of heart.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Difficult labor

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. Smiller, M. D.

8/22/30., 19 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho.

Date of Burial: 8/23/30. 19

20. Undertaker: Arthur W. Hall

Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71596

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5886

2. FULL NAME Alice Johnson

(a) Residence. No. Pingree, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 20, 1916

7. AGE Years 13 Months 9 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bingham Co Idaho

PARENTS

10. NAME OF FATHER Frank Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Ada Sanders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wyoming

14. Informant Frank Johnson
(Address) Pingree Idaho

15. Filed 8/22, 1930 J. K. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 21, 1930
that I last saw her alive on Aug 21, 1930
and that death occurred, on the date stated above, at 2:40 P m.
The CAUSE OF DEATH* was as follows:
Genl septic infection
Pneumonia abscess Lungs
Congestion lungs
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Septicaemia
about (duration) yrs. mos. 25 ds.

18. Where was disease contracted if not at place of death? Pingree
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Usual
(Signed) H. C. Dawson D.
8/21, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Thomas Kinnick
Date of Burial Aug. 24 1930

20. Undertaker E. T. Peck
Address Blackfoot

SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 715

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. St. Anthony's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5885

117

2. FULL NAME Frank Edward Edmonds

(a) Residence. No. 1030 East Lewis St. Poca., Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 3, 1910.

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	10	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Delivery Truck
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Hopper Dairy Co.

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho.

PARENTS

10. NAME OF FATHER: Tracy A. Edmonds

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kaysville, Utah.

12. MAIDEN NAME OF MOTHER: Letetia Creer

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spanish Fork, Utah.

14. Informant: Tracy A. Edmonds
(Address) 1030 East Lewis St. Poca., Ida.

15. Filed 8/21/30., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 19, 1930, that I last saw h[im] alive on Aug 19, 1930, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:
Gangrene Appendicitis

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Septic Pneumonia Flem

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? At this home, Pocatello
Did an operation precede death? Yes Date of 8/7/30
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) O. F. Reed, M. D.
8/20/30., 19.... (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	8/22/30. 19
20. Undertaker: Arthur W. Hall	Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7150

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 216 1

Local Registrar's No. 5884

(No. Ranch South Second Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Waichiro Uyeda

(a) Residence. No. Pocatello, Idaho. St. 164
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) June 18, 1879.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2	0	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer O. S. L. R. R.

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Arthur W. Hall (Coroner)

(Address) Pocatello, Idaho.

15. Filed 8/20, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 18, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Strangulation by Hanging.
(Suicidal)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Arthur W. Hall Coroner, M. D.

8/20/30., 19..... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	8/20/30. 19
20. Undertaker Arthur W. Hall	**Address** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 3 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

County of Bannock

Primary Registration District No. 2161

File No. 7150

City of Lava Hot Springs (No. Lava Hot Springs Hospital St.)

Registered No. 190

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cloe Myrtle Sharp Montague Cloe Montague

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married Wife of Lyonal A. Montague

6. DATE OF BIRTH: April (Month) 3, (Day) 1896, (Year)

7. AGE: 34 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Soda Springs, Idaho.

10. NAME OF FATHER: George W. Sharp

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Amanda Bair

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lyonal A. Montague

(Address) Lava Hot Springs, Idaho.

15. Filed Sept-1- 1930 Mrs. G. L. Fitz
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 117

August (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1930 to Aug 23 1930

that I last saw her alive on Aug 22 1930

and that death occurred on the date stated above, at 5 30a M.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix.

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary) none

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. A. Ruchi M. D.

8-23 1930 (Address) Lava Hot Springs.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs, Idaho. DATE OF BURIAL: 8/26/30

20. UNDERTAKER: Arthur W. Hall ADDRESS: Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH RECEIVED AUG 21 1930

County of Bannock

City of ~~Downey~~ Virginia

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ....., ... St.)

File No. 71666

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Yvonne Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1924 (Year)

7. AGE: 6 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl.
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Virginia, Idaho.

10. NAME OF FATHER: R. E. Davis

11. BIRTHPLACE OF FATHER (State or Country): Perry, Utah.

12. MAIDEN NAME OF MOTHER: Leona Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Downey Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Davis
(Address) Virginia

15. Filed Aug. 19 1930 Mary C. Coffin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 - 28 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-18-1930, to July-28-1930, that I last saw her alive on July-28-1930, and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:
Pertusser

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary): Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) H. J. Hartington, M. D.

7-30-1930 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey, Idaho.

DATE OF BURIAL: 7-30-1930

20. UNDERTAKER: None.

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED AUG 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71601

PLACE OF DEATH
County of Kootenai
City of Rimini

Registration District No. 83
Primary Registration District No. 2160
Local Registrar's No. 8

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ja Dene O. Henderson 9

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 2 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rimini
(State or country) Idaho

PARENTS

10. NAME OF FATHER Robt. W. Henderson
11. BIRTHPLACE OF FATHER (city or town) Robin
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Nina Jed Smith
13. BIRTHPLACE OF MOTHER (city or town) Robin
(State or Country) Idaho

14. Informant Robert W. Henderson
(Address) Rimini Idaho

15. Filed Aug 19, 1930 Mary C. Coffin
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to July 14, 1930
that I last saw her alive on July 13, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Pertussis (Whooping Cough)

..... (duration) ..... yrs. ..... mos. 32 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. E. Worthington, M. D.
7-16-1930 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rimini Ida.	July 17 1930
20. Undertaker	Address
J. Guy Hansen	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71802

PLACE OF DEATH
County of Kamiah
City of Arimo

Registration District No. 83
Primary Registration District No. 2160
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

164

2. FULL NAME Caroline Bendar Fink

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Martin Fink Ch.

6. DATE OF BIRTH (month, day and year) Feb. 24 - 1855

7. AGE Years 75 Months 4 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Joseph Bendar
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Juliana - - - -
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Chas Fink
(Address) Arimo Idaho

15. Filed Aug. 19, 1930 Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July - 19 - 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July - 19 -, 1930, to July 19, 1930
that I last saw her alive on July - 19 -, 1930
and that death occurred, on the date stated above, at 3:30 P.m.
The CAUSE OF DEATH* was as follows:
Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. J. Hartigsen, M. D.
7 - 21 -, 1930 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Marsh Center Ida
Date of Burial July 22 1930

20. Undertaker J. Guy Benson
Address Malad Ida

TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71603

PLACE OF DEATH
County of Benewah
City of St. Joe

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

114

2. FULL NAME Doris R Inman
(a) Residence. No. St Joe Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19 - 27

7. AGE: Years 3, Months 2, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) St Joe Ida

PARENTS

10. NAME OF FATHER Ray Inman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER Gertie Richardson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida

14. Informant Ray Inman
(Address) St Joe Ida

15. Filed Sept 5, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Aug 28th, 1930, to ..... 19..., that I last saw her alive on Aug 28th, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Gastro-enteritis, acute,

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam
(Signed) C A Robins, M. D.
9/2, 1930 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries
Date of Burial: Aug 30 1930 ✓

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71664

PLACE OF DEATH

County of Benewah

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 31

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Frank Domains

(a) Residence. No. ..... St. Clarkia Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: 50 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Rutledge Lumber Co

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Mrs C W Benscotter
(Address) Clarkia Ida

15. Filed Aug 10, 1930 Walter Roberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5, 1930, to August 6, 1930 that I last saw him alive on August 6, 1930 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows: Shock following compound fracture left femur - fracture rt fibula multiple contusions & abrasions

Accidental (duration) ..... yrs. ..... mos. 18 hrs

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? amputation leg

Did an operation precede death? Yes Date of 8/5/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Cornwall, M. D.

....., 19..... (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries — Date of Burial: Aug 8 1930

20. Undertaker: Geo E Mitchell — Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71665

PLACE OF DEATH

County of Benewah

City of St Maries
Ramsdell

Registration District No. 32

Primary Registration District No. 2049

Local Registrar's No. 30

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

305-B

2. FULL NAME Albert Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years: 54 Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: John Olson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Stina Gabrielson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Alfred Johnson
(Address) 226½ N Stevens St Spokane

15. Filed Aug 10, 1930 Walter Coberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Unknown 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) B. Vespe Coroner, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida. Date of Burial: Aug 7 1930

20. Undertaker: Geo E Mitchell Address: St Maries

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71606

PLACE OF DEATH

County of Benewah

City of Plummer

CERTIFICATE OF DEATH

Registration District No. 46

Primary Registration District No. 2123

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 4

2. **FULL NAME** Ada Porter

(a) Residence. No. St. Rose Lake. Ida. 74a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Hugh Porter

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10 NAME OF FATHER: Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Hugh Porter

(Address) Rose Lake Ida

15 Filed Aug 30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 31 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Called after death, 19 to 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebro Hemorrhage

10 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Stethascope

(Signed) J. J. Henningson M. D.

Aug 31st 1930 (Address) Hooley. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~: Rose Lake Cemetary

Date of Burial: Sept 3 1930

20. Undertaker: H. G. Jaeger

Address: Plummer Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 8 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Benewah State Idaho Registered No. 13
Township De Smet or Village 71607 or
City ..... No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Richard Joseph Nicodemus

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M
4 COLOR OR RACE: Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 25 - 1924

7 AGE: Years 6 | Months 5 | Days 13 | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) Spokane
(State or country) Wash

PARENTS
10 NAME OF FATHER Joseph Nicodemus
11 BIRTHPLACE OF FATHER (city or town) Coeur d'Alene
(State or country) Reservation
12 MAIDEN NAME OF MOTHER Thresa Mary Campbell
13 BIRTHPLACE OF MOTHER (city or town) Coeur d'Alene
(State or country) Reservation

14 Informant Bazile Campbell
(Address) Tekoa Wn

15 Filed Aug. 10, 1930 John Post
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to April, 1930, that I last saw ~~him~~ alive on April, 1930, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(SECONDARY)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
(Address) Tekoa Wn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: C. L. Schulcrud De Smet, Idaho
DATE OF BURIAL: Aug 10 1930

20 UNDERTAKER: C. L. Schulcrud
ADDRESS: Tekoa, Wash

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—209 d
V. S. No. 98

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71608

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 131

Primary Registration District No. 2194

Local Registrar's No. 131

(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME KATE KRUSE

(a) Residence. No. ..... St. Ada County
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 84 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Henry Allen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Susan Benner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14. Informant: Grace A Clippinger R.N.
(Address) Blackfoot, Ida.

15. Filed Aug 18, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 16th, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14th, 1930, to Aug 16th 1930, 19

that I last saw her alive on Aug 16th 1930, 19

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia - lobar

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. E. Patrick, M. D.

Aug 18 1930, 19 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairfield Idaho | Date of Burial: Warrenal 19

20. Undertaker: E J Peck | Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71609

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 2194
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 130

41

2. FULL NAME Mary Street.

(a) Residence. No. ..... St. St Anthony
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
(or) WIFE of --- Jacob Street

6. DATE OF BIRTH (month, day and year) May 6-1844

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	3	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER John Meiser

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Annie Otts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Lillian Moore, Att.
(Address) Blackfoot, Ida.

15. Filed Aug 31, 1930 Mrs Helen E. Catron Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 29th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1927, 19..., to Aug 29-1930, 19...
that I last saw her alive on Aug 29th, 1930, 19...
and that death occurred, on the date stated above, at 4:35 P m.
The CAUSE OF DEATH* was as follows:

Septicemia

..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) Abscess on left Shoulder
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams, M. D.
Aug 30, 1930 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wilford, Idaho — Date of Burial Sept. 2-1930

20. Undertaker N. M. Hansen — Address St. Anthony Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71610

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 129

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Arthur Bernard Stowe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feby 16 1898

7. AGE: 32 Years | Months: 6 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mo

PARENTS

10. NAME OF FATHER: A W Stowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oklahoma
12. MAIDEN NAME OF MOTHER: Josephine White
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Velma Stowe
(Address): Shelley Ida

15. Filed Aug 28, 1930 Mrs Helen E Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Aug 27, 1930
that I last saw him alive on Aug 27, 1930
and that death occurred, on the date stated above, at 12 14 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No ✓
What test confirmed diagnosis?
(Signed) F W Pickett, M. D.
Aug 27, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Drexel, Mo. | Date of Burial: 19

20. Undertaker: F Peck | Address: Blackfoot

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71617

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194

Local Registrar's No. 127

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1-4

2. FULL NAME Arnold Allen Durrant

(a) Residence. No. Blackfoot, Idaho R. F. D. 3 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 10, 1924

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	1	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Blackfoot, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Arthur A. Durrant

11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)

12. MAIDEN NAME OF MOTHER Lilla Okesseon

13. BIRTHPLACE OF MOTHER (city or town) Sweden
(State or Country)

14. Informant A A Durrant
(Address) Blackfoot, Idaho

15. Filed Aug 25 '30 Mo Valentine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 23, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to Aug. 22, 1930
that I last saw him alive on August 22, 1930
and that death occurred, on the date stated above, at 11:30A m.

The CAUSE OF DEATH* was as follows:
Spastic Paraplegia due to an injury.

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted X
if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical findings

(Signed) J. D. Hampton, M. D.
Aug. 23, 1930 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	Aug. 25, 1930
20. Undertaker	Address
Modern Mortuary	Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71613

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2694.

Local Registrar's No. 126

(No. Sugar Factory Boarding House 1/2 mi. No. [illegible])

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LaVon Middleton

(a) Residence. No. Blackfoot, Sugar Factory St. 90
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 25. 1913.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	5	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER John R. Middleton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eng.

12. MAIDEN NAME OF MOTHER Martha Joane Preston.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah.

14. Informant Mrs J. R. Middleton
(Address) Blackfoot, Ida.

15. Filed Aug. 23, 1930. Mrs Valerie E. Caterie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 22, 1930 that I last saw her alive on Aug 22, 1930 and that death occurred, on the date stated above, at 12:15 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) J. O. Hagerstein M. D.

8-23, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	Aug. 24-30 19

20. Undertaker	Address
Modern Mortuary, Blackfoot.	

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71611

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 125

75

2. FULL NAME Edward Lincoln Scott
(a) Residence. No. Blackfoot Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle M Scott

6. DATE OF BIRTH (month, day and year)

7. AGE: 65 Years | Months: 9 | Days: 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Plattsburg Mo

PARENTS

10. NAME OF FATHER: Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: L C Collins
(Address): Blackfoot Idaho

15. Filed: Aug 21, 1930 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 20 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 20, 1930
that I last saw him alive on Aug 20, 1930
and that death occurred, on the date stated above, at 6.40 a.m.
The CAUSE OF DEATH* was as follows:
General paralysis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary): Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) F. A. Mitchell, M. D.
Aug 21, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lathrop Mo. | Date of Burial: 19

20. Undertaker: E J Peck | Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7161

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 123

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME LAURA A SMITH

(a) Residence. No. ..... St. Boise, Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
(or) WIFE of Mitchell Smith

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Milton Ashlev

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia Missouri

12. MAIDEN NAME OF MOTHER Mary Ashley

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Minnie Hayes-Attendant
(Address) Blackfoot

15. Filed Aug 8, 1930 Walter E. Calvin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 7th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27th, 1930 to Aug. 7th, 1930
that I last saw her alive on Aug. 7th, 1930
and that death occurred, on the date stated above, at 3 PM m.
The CAUSE OF DEATH* was as follows:

Purulent Infection

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age General Debility.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Aug 7th, 1930 (Address) Blackfoot.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Baker Oregon	
20. Undertaker E J Peck	Address Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7161

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 122
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

76

2. FULL NAME DAVE FAYLE

(a) Residence. No. ... St. Salmon Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Grace A Clapperger R.N.
(Address) BLACKFOOT. Ida.

15. Filed Aug 6, 1930 Mrs Walter E. Petrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 6th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st, 1927, 19..., to Aug. 6th, 1930, 19...
that I last saw h im alive on Aug. 5th, 1930, 19...
and that death occurred, on the date stated above, at 12:30A m.
The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Aug 6th 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boylan Cem.	Aug 6 1930
20. Undertaker	Address
Mason Celark	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71618

PLACE OF DEATH

County of Bingham

City of Groveland

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 121

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

183

2. FULL NAME Leonard Fredrick Blood

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May 23 1904

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	2	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Groveland Idaho

PARENTS

10. NAME OF FATHER: Elmer R. Blood

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Minnie Winroath

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: Elmer R. Blood
(Address): Blackfoot Idaho

15. Filed Aug 5, 1930 Mrs Hattie E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 4th. 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Gunshot wound in face and head.

Accidental.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? None

What test confirmed diagnosis? Witnesses.

(Signed) Ray McClellan, ~~M.D.~~ County Coroner.

Aug. 5. 1930 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Groveland Idaho

Date of Burial: —— 19

20. Undertaker: E J Peck

Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71619

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 2144

Local Registrar's No. 120

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME EMMA MARY CASPER

(a) Residence. No. ..... St. IDAHO FALLS
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

600

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word): MARIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of CASIUS CASPER

6. DATE OF BIRTH (month, day and year)

7. AGE: 42 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo, Utah

PARENTS

10. NAME OF FATHER John Titus Waters

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Provo, Utah

12. MAIDEN NAME OF MOTHER Alameda Richmond

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Grace A Clippinger R.N.
(Address) Blackfoot, Ida.

15. Filed Aug 1, 1930 Mrs Walter E. Patrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 1st, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Apr. , 19 , to Aug. 1-1930 , 19
that I last saw her alive on Aug 1 1930 , 19
and that death occurred, on the date stated above, at 9:58 A m.
The CAUSE OF DEATH* was as follows:

Goitre

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Melancholy

(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Yes Date of Mar. 1930
Was there an autopsy? No
What test confirmed diagnosis? None Phys. signs
(Signed) W. E. Patrie act. temp. supt. , M. D.
Aug 1st, 1930 (Address) Blackfoot, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho | Date of Burial: 8/3 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

RECEIVED AUG 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Boise
City of
Registration District No.
Primary Registration District No. Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Locke Lee

(a) Residence. No. St. 204
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Chinese	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 94			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address)

15. Filed Aug 16 1930 Jno E S Robison Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Found dead.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Idaho City Idaho — Date of Burial Aug 1930

20. Undertaker — Address Idaho City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71C[illegible]

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 64

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Squeque 90

(a) Residence. No. Ronan, Mont St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Red
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 45 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ~~Unk~~ Montana

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Montana
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Montana

14. Informant: Mrs Squeque
(Address) Ronan Mont

15. Filed Aug 29, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Aug 28, 1930
that I last saw him alive on Aug 28, 1930
and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Floyd G. Beadle M. D.
Aug 29, 1930 (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Ignatius Mont | Date of Burial: Aug 30 1930

20. Undertaker: Turnbull Co | Address: Sandpoint

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71625

PLACE OF DEATH
County of BONNER
City of SANDPOINT
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 69
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

A86a

2. FULL NAME ELDON FORSYTHE

(a) Residence. No. St. DRAKE, NORTH DAKOTA
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) FEBRUARY 18, 1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	5	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work STUDENT
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) GLENWOOD MINN

PARENTS

10. NAME OF FATHER FRED W. FORSYTHE

11. BIRTHPLACE OF FATHER (city or town) (State or Country) BLOOMINGTON ILL.

12. MAIDEN NAME OF MOTHER MABLE E. DICKIRSON

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) GARNER IOWA

14. Informant FRED W. FORSYTHE
(Address) Box 14 DRAKE, NORTH DAKOTA.

15. Filed Aug 20, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH AUGUST (Month) 17th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at 6:44 a.m.

The CAUSE OF DEATH* was as follows:
STRUCK BY RAILWAY TRAIN
ACCIDENTAL
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) FRACTURED SKULL
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) CORONER, M. D.
AUGUST 18th, 1930 (Address) SANDPOINT, IDAHO.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
SAN DIEGO, CALIFORNIA	19

20. Undertaker	Address
MOON MORTUARY	SANDPOINT, IDAHO

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71626

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 69
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred Kitchen

(a) Residence. No. 502 Superior St St. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Kitchen

6. DATE OF BIRTH (month, day and year) April 27, 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	3	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Brunswick Canada

PARENTS
10. NAME OF FATHER Joseph Kitchen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Jane West
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs. Alice Kitchen
(Address) Sandpoint, Idaho.

15. Filed Aug 13, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 11, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to Aug 11, 1930
that I last saw him alive on Aug 10, 1930
and that death occurred, on the date stated above, at 4:00 a.m.
The CAUSE OF DEATH* was as follows:

Sarcoma involving right lung.
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Sarcoma left thigh.
Amputated 1928 (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1929
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Wm F. Tyler, M. D.
Aug 13, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Aug. 13, 1930
20. Undertaker	Address
L. G. Moon	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7162

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 61
(No. 709 N Third)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1848

2. FULL NAME Gustave Sundeen

(a) Residence. No. 709 N Third St.
(Usual place of abode)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 5 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	5	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Unobtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs P.A. Nelson
(Address) Sandpoint Idaho

15. Filed Aug 2, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug 1, 1930
that I last saw him alive on Aug 1, 1930
and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:
Accidental traumatism.
(Fracture right femur)
Automobile accident
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Shock. Arteriosclerosis (Senility.)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical and X Ray

(Signed) Wm F. Tyler, M. D.
Aug 2, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	8/5 1930
20. Undertaker	Address
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71628

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 14
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Jones

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 26 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Shepphard Jones

6. DATE OF BIRTH (month, day and year) August 29, 1834

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	95	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Peter B. Wallace
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Fred Jones
(Address) Priest River, Idaho.

15. Filed Aug 20, 1930 R. E. Nevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 19th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1110 P m.

The CAUSE OF DEATH* was as follows:
Unknown: Probable Chronic Interstitial Nephritis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) L. E. Moon. Coroner M. D.
Aug. 20, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	aug. 21 1930
20. Undertaker	Address
Moon Mortuary	Priest River, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21C[illegible]

PLACE OF DEATH
County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William John Marquette

(a) Residence. No. 182 St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lilliah Edwards

6 DATE OF BIRTH (month, day and year) July 2, 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Humbird Lumber Co.

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS
10 NAME OF FATHER William A. Marquette
11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada
12 MAIDEN NAME OF MOTHER Hannah King
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mrs. Julia Upton
(Address) Newport, Wash.

15 Filed Aug. 15, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 8, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h... alive on ..., 19...,
and that death occurred, on the date stated above, at 9:45A. m.

The CAUSE OF DEATH* was as follows:
Accidental Drowning.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) L. R. Moon Coroner.
Aug. 12, 1930. (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F. Cemetery	Aug. 16 1930

20. Undertaker — Address
Moon Mortuary — Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 5

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7163

PLACE OF DEATH

County of Bonner

City of Priest River

Registration District No. 85

Primary Registration District No. 2185

Local Registrar's No. 12

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ralph Evans 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	46			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Logger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Emil Erickson

(Address) Priest River, Idaho

15. Filed Aug 3, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 2¼ P m.

The CAUSE OF DEATH* was as follows:

Unknown Chronic Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcholism

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) L. L. Broom Coroner M. D.

Aug 2, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Aug 3 1930
20. Undertaker	Address
Moon Mortuary	Priest River, Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED SEP 16 1930

DO NOT WRITE IN THIS SPACE

State File No. 71631

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 3

Primary Registration District No. 1V-D

Local Registrar's No. 1V-V

(No. L.D.S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

137

2. **FULL NAME** Eileen Cobia Christensen

(a) Residence. No. ..... St. American Falls

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced, (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Albert Christensen

6. DATE OF BIRTH (month, day and year) Dec. 11, 1895

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	8	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10. NAME OF FATHER Wm N. Cobia

11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Carolina

12. MAIDEN NAME OF MOTHER Mary Placedie James

13. BIRTHPLACE OF MOTHER (city or town) (State or County) South Carolina

14. Informant Mrs W C. Foster
(Address) 344 Memorial Drive Idaho Falls

15. Filed 9/16, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 15, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930 to Aug 15, 1930
that I last saw her alive on Aug 15, 1930
and that death occurred, on the date stated above, at 4:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pyelonephritis & Uremic Cyst

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? American Falls, Ida.
Did an operation precede death? Yes Date of Aug 13-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) ..... M. D.
Aug 16, 1930 (Address) Idaho Falls, Idaho

19. Place of Burial, Cremation, or Removal: Salt Lake City, Utah — Date of Burial: Aug 18 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71633

PLACE OF DEATH

County of Bonneville.

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2100

Local Registrar's No. 1174

(No. Idaho Falls L.D.S. Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

111a

2. FULL NAME Theodore John Durant.

(a) Residence. No. ..... St. Rigby, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or ~~XXXXXX~~ Eliza Durant.

6. DATE OF BIRTH (month, day and year) May 28, 1867

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63	2	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS

10. NAME OF FATHER: James Durant.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Ann Morris.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant J. R. Durant
(Address) Rigby, R. #3

15. Filed 8/15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August, 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Aug 4, 1930 that I last saw him alive on Aug 4, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: following operation for gastro-jejunal-colic ulcer.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Gastroenterostomy for duodenal ulcer (duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Aug 1, 1930

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) H Ray Hatch M. D.

Aug 8, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shelton. Date of Burial: 8/7 1930

20. Undertaker: A B Eckersell Address: Rigby

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 2 IV-0
Local Registrar's No. IV-3
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Carolina Staples
(a) Residence. No. ..... St. Route #5 161a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27, 1930

7. AGE Years | Months | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Paul A. Staples
11. BIRTHPLACE OF FATHER (city or town) Monroe, Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Edith Jones
13. BIRTHPLACE OF MOTHER (city or town) Ammon, Idaho
(State or County)

14. Informant (Address) Paul A. Staples Idaho Falls Rt. #5.

15. Filed 7/12, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 11 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930, to Aug 11, 1930
that I last saw her alive on Aug 7, 1930
and that death occurred, on the date stated above, at 4-30 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature birth
7 months
due to accidental rupture of amniotic sac
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Malnutrition
(duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? LDS Hosp.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) [signature] M. D.
8/11, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho
Date of Burial: August 12 1930

20. Undertaker: Jack A. Wood
Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21[illegible]

Registration District No. 73
Primary Registration District No. 2-1-5-0
Local Registrar's No. 1 V 2

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

(No. L. D. S. Hospital) 66
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Paul E. Larsen

(a) Residence. No. [illegible] St. Squirrel Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Ingeborg L. Larsen

6. DATE OF BIRTH (month, day and year): August 16, 1852

7. AGE — Years: 78 | Months: 11 | Days: 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10. NAME OF FATHER: Ole E. Patt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Olof R Larsen
(Address): Squirrel Idaho

15. Filed Aug 6, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar Bilateral
Otitis Media

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis? X Ray Dutton

(Signed) ..., M. D.
Aug 6, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton Idaho	Aug 8 1930
20. Undertaker: Jack A. Wood	Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71625

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 22
Primary Registration District No. 21 N-0
Local Registrar's No. 107

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha Jane Wyatt

(a) Residence. No. ... St. Idaho Falls Rt #7
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of: John B. Wyatt

6. DATE OF BIRTH (month, day and year): April 22, 1883

7. AGE: Years 47 | Months 3 | Days 11 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Hyrum, Utah

PARENTS

10. NAME OF FATHER: Niels Hartingsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Mat Knudsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: John B. Wyatt
(Address): Idaho Falls Rt #7

15. Filed Aug 6, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1930, to Aug 3, 1930
that I last saw her alive on July 28, 1930
and that death occurred, on the date stated above, at 9:15 a.m.
The CAUSE OF DEATH* was as follows:

~~Accidental Burns~~
Cerebral Hemorrhage
(duration) ... yrs. ... mos. 4 Days

CONTRIBUTORY ~~Myocarditis~~ (Secondary) Arterial Sclerosis
(duration) 3 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood Pressure

(Signed) ... M. D.
8/11, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burton Idaho — Date of Burial: Aug 5 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71626

PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 2120 Local Registrar's No. 11-0

(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Nettie Arehart

(a) Residence. No. R.F.D. #5 St. 112
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. H. Arehart

6 DATE OF BIRTH (month, day and year): May 12 1875

7 AGE: Years 55 Months 2 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS
10 NAME OF FATHER: Billman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Cleveland Ohio?
12 MAIDEN NAME OF MOTHER: Elizabeth Barnes (Unknown)
13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: J. H. Arehart
(Address): Idaho Falls Ida

15 Filed Aug 5, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August 2 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 2-30, 1930, to Aug 2, 1930, that I last saw her alive on Aug 2nd, 1930, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows: Acute indigestion

(duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary): Hernia and probably Heart. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. W. Pendleton M. D.
Aug 5, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Ucon Idaho
Date of Burial: Aug. 7 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71C...

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. B

City of Idaho Falls Primary Registration District No. 2150 Local Registrar's No. 149

(No. Le De S. Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lena Seyfert 88 B

(a) Residence. No. 3 miles So of I F St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (Write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 1868

7 AGE Years 61 Months 8 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Missouri Cal.

PARENTS

10 NAME OF FATHER Funke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margarette Seyfert

(Address) Idaho Falls Ida

15 Filed Aug 5, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 1 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Aug 1, 1930, that I last saw her alive on Aug 1, 1930, and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) [signature], M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial: 8/4 1930

20. Undertaker: V. F. McHan — Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71639

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 147

205-B

2. FULL NAME Isaac Norton
(a) Residence. No. Idaho Falls R.F.D. # 4 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 24, 1837

7. AGE Years 93 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS
10. NAME OF FATHER John Norton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mississippi
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U. S. A.

14. Informant Mrs. E. A. Huntsman
(Address) Woodville, Idaho

15. Filed Aug 2, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12-10 a m.
The CAUSE OF DEATH* was as follows:

no medical attendance

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ....., M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Woodville, Idaho — Date of Burial Aug 3 1930

20. Undertaker Jack A. Wood — Address Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71C[illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 16B
166
(No.) 161a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Wardle Gordon
(a) Residence. No. 198 - E - 11th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 22

7. AGE Years | Months | Days | If LESS than 1 day, 8 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida

PARENTS
10. NAME OF FATHER Arthur Harold Gordon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mercer Utah
12. MAIDEN NAME OF MOTHER Polly Ruth Wardle
13. BIRTHPLACE OF MOTHER (city or town) (State or County) West Jordan Utah

14. Informant (Address) Arthur H. Gordon 198 E - 11th Idaho Falls

15. Filed Aug 25, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1930, to Aug 23, 1930
that I last saw him alive on Aug 23, 1930
and that death occurred, on the date stated above, at 4 am m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature Birth (6½ months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Laceration of Mothers Cervix

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? [signature]
(Signed) J. Mess, M. D.
8/24, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Rose Hill
Date of Burial Aug. 24 1930

20. Undertaker Jack A. Wood.
Address Idaho Falls.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71641

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 165

101a

2. FULL NAME Lyda Ann Hutchinson Riley
(a) Residence. No. Ashton Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Pete Riley

6. DATE OF BIRTH (month, day and year) Feby 20 · 1892

7. AGE Years 38 Months 6 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Wm Hutchinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Cynthia Spencer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Cynthia Hutchinson
(Address) Blackfoot Ida

15. Filed Aug 25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Aug 25, 1930
that I last saw her alive on Aug 24 1930
and that death occurred, on the date stated above, at 12 15 9 m.
The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Acute Tonsillitis
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Ashton Idaho
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [signature], M. D.
, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot Ida. Date of Burial Aug 1930

20. Undertaker J. Wood Address Idaho Falls Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7[illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-D
(No. L. D. S. Hospital) Local Registrar's No. 164
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leon Albert Brown

(a) Residence. No. ..... St. Rigby Route # 2
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 16, 1898

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	8	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Shelton, Idaho

PARENTS

10. NAME OF FATHER Albert Wm Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah
12. MAIDEN NAME OF MOTHER Clara M Page
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bountiful, Utah

14. Informant Albert Wm Brown
(Address) Rigby Route #2

15. Filed Aug 23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 21, 1930
that I last saw him alive on Aug 21, 1930
and that death occurred, on the date stated above, at 5-50 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Sarcoma of Lung (Right)
(duration) ..... yrs. ..... mos. 3 wks
CONTRIBUTORY (Secondary) Sarcoma of leg
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? [illegible] of leg
Did an operation precede death? yes Date of 1928
Was there an autopsy? .....
What test confirmed diagnosis? Sputum

(Signed) [signature], M. D.
8-22, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Shelton, Idaho — Date of Burial: Aug 23 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

NT RECORD
stated EXACTLY, PHYSICIANS should
assified. Exact statement of OCCUPATION is

FORM V. S. No. 5-25 M. 1-19. SEP 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. [illegible]

Local Registrar's No. 163

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 2141-0

(No. ..... St.)

2. FULL NAME Ray Belnap Miskin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): newborn

6. DATE OF BIRTH: August (Month) 19 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida.

10. NAME OF Father: Arthur R. Miskin

11. BIRTHPLACE OF FATHER (State or Country): St. John, Kansas

12. MAIDEN NAME OF MOTHER: Lurvina Belnap

13. BIRTHPLACE OF MOTHER (State or Country): Hooper, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur R Miskin

(Address) Ucon, Idaho

15. Filed Aug 21 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH 161a

16. DATE OF DEATH: August (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1930, to Aug 19 1930, that I last saw him alive on Aug 19 1930, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature 8 months

Lived 8 hrs

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Separation of Placenta

(Duration) ..... yrs. ..... mos. 8 hrs ds.

(Signed) [signature] M. D.

8/20 1930 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence Ucon

19. PLACE OF BURIAL OR REMOVAL: Ucon Idaho — DATE OF BURIAL: Aug 21 1930

20. UNDERTAKER: Jack A. Wood — ADDRESS: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 1 N-0
Local Registrar's No. 162
(No. Idaho Falls L. D. S. Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. **FULL NAME** Jean James Holland.

(a) Residence. No. ..... St. Rigby, Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Babe

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 8 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho.

PARENTS

10. NAME OF FATHER James Murdell Holland.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grant, Idaho.
12. MAIDEN NAME OF MOTHER Eva Lota Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grant, Idaho.

14. Informant J. M. Holland
(Address) Rigby, Idaho.

15. Filed Sep 22, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
Aug 18, 1930, to Aug 18, 1930
that I last saw h[illegible] alive on Aug 17, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Intussusception

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Rigby, Idaho
Did an operation precede death? Yes Date of Aug 17
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [illegible], M. D.
..... 19..... (Address) .....

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby Ida.	8/19 1930
20. Undertaker	Address
[illegible]	Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71645

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2110
(No.)
Local Registrar's No. 161

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Patricia Payne

(a) Residence. No. L.D.S. Hospital St. 161a

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) August 18, 1930

7 AGE Years Months Days If LESS than 1 day, 16 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10 NAME OF FATHER J.Henry Payne Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho Falls, Idaho

12 MAIDEN NAME OF MOTHER Mary Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho Falls, Idaho

14 Informant Mrs. H.D.Payne
(Address) R.D.#2 Idaho Falls, Idaho

15 Filed Aug 21, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August (Month) 18 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Aug. 18, 1930, that I last saw h~~e~~r alive on Aug. 18, 1930, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Premature. Defective Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Harry L. Wilson, M. D.

8/19, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL. or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~ Idaho Falls, Idaho — Date of Burial Aug. 19 30

20. Undertaker by
V. F. McHan / O. E. Buck
Address

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71646

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2143
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 160

151

2. FULL NAME Isabell Wann Shelton Harder
(a) Residence. No. St Anthony Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 6 1867

7. AGE Years 63 Months 6 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meridian Wash

PARENTS
10. NAME OF FATHER John Shelton
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Mary Wann Shelton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant August L. Harder
(Address) Mesa Arizona

15. Filed 9/20, 1930 Guy Kinnaird Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 20 1930
that I last saw her alive on Aug 20, 1930
and that death occurred, on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:
Gangrene of left leg due to erysipelas
(duration) yrs. 2 mos. — ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis and Obesity (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) H Ray Hatch M. D.
Aug 20, 1930 (Address) H Ray Hatch 2204 Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Anthony
Date of Burial Aug 24 1930

20. Undertaker Alvin Keller
Address Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 11-0 Local Registrar's No. 10-9
(No. I. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Robert Andrus Phillips
(a) Residence. No. St. Ucon, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 18, 1930

7. AGE Years Months Days If LESS than 1 day, 6 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS
10. NAME OF FATHER John Phillips
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Preston, Idaho
12. MAIDEN NAME OF MOTHER Lavina Minnie Andrus
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ucon, Idaho

14. Informant (Address) John O. Phillips Ucon, Idaho

15. Filed 8/20, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Aug 18, 1930
that I last saw him alive on Aug 18, 1930
and that death occurred, on the date stated above, at 7 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Birth
(7 mo 1 wk)
Lived 6 hrs 40 min
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General weakness of Mother.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Ucon
Did an operation precede death? Philobuth Date of
Was there an autopsy? no
What test confirmed diagnosis? Pregnancy History
(Signed) [signature] M. D.
8/18, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Ucon, Idaho
Date of Burial Aug 19 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 IV-0
Local Registrar's No. IV-1
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Clora Pratt Phillips
(a) Residence. No. 278-5th Street St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 10, 1880

7. AGE Years 50 Months 7 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Haysville, Utah

PARENTS
10. NAME OF FATHER George C. Pratt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York City, N. Y.
12. MAIDEN NAME OF MOTHER Olive Hunt
13. BIRTHPLACE OF MOTHER (city or town) (State or County) San Bernardino California

14. Informant (Address) Miss Nettie Pratt Idaho Falls, Idaho

15. Filed 8/20, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Aug 17, 1930
that I last saw her alive on Aug 17, 1930
and that death occurred, on the date stated above, at 11-15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of June 10, 1929
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial Aug 20 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71649

PLACE OF DEATH

County of Bonneville.

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 1V-2

(No. Idaho Falls L. D. S. Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1V-7

100a

2. FULL NAME Bernadean Thornton.

(a) Residence. No. ..... St. Rigby, Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Babe

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 10, 1929

7. AGE

Years	Months	Days	If LESS than 1 day,
0	10	1	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Babe

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10. NAME OF FATHER: Edmond Earl Thornton.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Pearl Connell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: E. E. Thornton
(Address) Rigby, Idaho.

15. Filed 8/18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 11 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 11, 1930 that I last saw her alive on Aug 11, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H R Hatch, M. D.

Aug 12, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho.

Date of Burial: 8/13/30 19

20. Undertaker: A B Eckwall

Address

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L.O.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14-6

1162

2. FULL NAME Lucile Mary Bledsoe
(a) Residence. No. West 21st & Roland St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 23, 1926

7. AGE Years 4 Months 5 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newdale Idaho

PARENTS
10. NAME OF FATHER Marion Bledsoe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Mary Niederer
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Marion Bledsoe Idaho Falls, Idaho

15. Filed Aug 14, 1930 C. Kennard Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-10, 1930, to Aug. 15, 1930
that I last saw her alive on Aug 15, 1930
and that death occurred, on the date stated above, at 11-30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis following information of bowels. Caused from Green apples.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. B. Dutton, M. D.
August 14, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Archer, Idaho
Date of Burial Aug 18 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71651

PLACE OF DEATH
County of Butte
City of Arco.

Registration District No. 59
Primary Registration District No. 2129
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

2. FULL NAME Nels A. Jeppesen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Jeppesen

6. DATE OF BIRTH (month, day and year) Oct. 17-1867

7. AGE Years 62 Months 9 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bear River City, Utah

PARENTS
10. NAME OF FATHER Nels. Jeppesen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Dorothy M. Nichols
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mary Ann Jeppesen
(Address) Arco Ida

15. Filed July 26, 1930 T. Butt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1929, to July 23, 1930 that I last saw him alive on July 23 1930 and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Hadritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical exam
(Signed) T. N. Egbert M. D.
July 23, 1930 (Address) Arco Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Theo R. Garnier
Date of Burial July 29 1930

20. Undertaker Hyrum, Utah
Address Arco

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71659

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 28

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John H. Scott

41

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6. DATE OF BIRTH (month, day and year): Nov. 17 - 1855

7. AGE: 74 Years | Months: 8 | Days: 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ranching and Mining
(b) General nature of industry, business, or establishment in which employed (or employer): Owner
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Quincey Ill.

PARENTS
10. NAME OF FATHER: ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓

14. Informant: B. F. Morrison
(Address): Martin Ida.

15. Filed July 24, 1930. T. C. Salt, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1931, to July 23, 1930
that I last saw him alive on July 22, 1930
and that death occurred, on the date stated above, at 7:20 A m.
The CAUSE OF DEATH* was as follows:
Septicemia from Diabetic Gangrene
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary): Diabetes - Myocarditis
..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical exam
(Signed) J. H. Egbert M. D.
July 23, 1930 (Address) Arco Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Arco Idaho | Date of Burial: July 24 1930
20. Undertaker: Theo R. Garnier | Address: Arco

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7165

PLACE OF DEATH
County of Butte
City of Arco, Ida

Registration District No. 59
Primary Registration District No. 2129
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

2. FULL NAME George Williamson Sutton

(a) Residence. No. 90 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriett Jane Sutton

6. DATE OF BIRTH (month, day and year): Oct. 4 - 1853

7. AGE: Years 76 | Months 9 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): x
(c) Name of employer: x

9. BIRTHPLACE (city or town) (State or country): Cherokee County North Carolina

PARENTS

10. NAME OF FATHER: un known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): English -

12. MAIDEN NAME OF MOTHER: (?) Montgomery

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): unknown

14. Informant: Joann Sutton
(Address): Arco Idaho

15. Filed July 23, 1930. T. O. Salt Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1929, to July 21, 1930, that I last saw him alive on July 21 1930 and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical exam

(Signed) H. H. Gilbert, M. D.
July 23, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Arco Idaho — Date of Burial: July 23 1930

20. Undertaker: Theo. R. Garmin — Address: Arco, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71654

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. FULL NAME Not named.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Infant.

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Infant

6. DATE OF BIRTH (month, day and year): July 6 - 1930

7. AGE: Years | Months | Days | If LESS than 1 day, ... hrs. or 5 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country): Arco Idaho

PARENTS

10. NAME OF FATHER: Thomas J. Hocking
11. BIRTHPLACE OF FATHER (city or town) (State or country): Little River Oklahoma
12. MAIDEN NAME OF MOTHER: Clara Verna King
13. BIRTHPLACE OF MOTHER (city or town) (State or country): Oklahoma

14. Informant: Thomas J. Hocking
(Address): Howe, Idaho

15. Filed July 7, 1930 F. C. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to July 6, 1930
that I last saw her alive on July 6, 1930
and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Premature (5-1/2 months)
Placenta Previa.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) D. H. Egbert, M. D.
July 7, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED SEP 12 1930

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 95
(No. 1 If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Jacob Williams. 179

(a) Residence. No. Homedale Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Service Station Attendant
(b) General nature of industry, business, or establishment in which employed (or employer) Agt.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Illinois

PARENTS
10. NAME OF FATHER Edward Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant Estelle Williams
(Address) Aberdeen Wash

15. Filed 8-12-, 1930. John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug -8- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 8, 1930, that I last saw him alive on Aug 8, 1930, and that death occurred, on the date stated above, at 6-15 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Burns suffered Aug 8
Body

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Homedale Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) [illegible] M D.
8-9, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Payne Cem. Date of Burial: 8/10 1930

20. Undertaker: C. V. Peckham Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 21[illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 96
(No.) 483
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lavina Eleanora Sparks

(a) Residence. No. Notus #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 6-9-1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	6	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Union Co.
(State or country) Georgia

PARENTS

10. NAME OF FATHER John Freeman
11. BIRTHPLACE OF FATHER (city or town) Georgia
(State or Country)
12. MAIDEN NAME OF MOTHER Sarah Teague
13. BIRTHPLACE OF MOTHER (city or town) Georgia
(State or County)

14. Informant W. C. Starkey
(Address) Nampa #3

15. Filed 6-13-, 1930. John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug - 9 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mon, 1930, to Aug 9 1930
that I last saw h[illegible] alive on Aug 1 1930
and that death occurred, on the date stated above, at 6-30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) W. M. Montgomery M. D.
8/11, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal: Rosewell Cem. Date of Burial: Aug 11 1930
20. Undertaker: S. V. Packham Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 97
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Miss Rae Beverly Curtis

(a) Residence. No. R F D No.2 Caldwell Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mch 18 1923

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	4	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grover Colo.

PARENTS

10. NAME OF FATHER Ellis H.Curtis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hays Center Nebr

12. MAIDEN NAME OF MOTHER Nellie Mullikin

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lincoln Nebr

14. Informant Ellis H.Curtis
(Address) R F D 2 Caldwell Idaho

15. Filed 8-15-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 14, 1930
that I last saw h[illegible] alive on Aug 12, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Ascending Paralysis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

8/15, 1930 (Signed) [illegible] M D
(Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	8-17-30 19
20. Undertaker	Address
Paul L.Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71658

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 98
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Artamisha Alemeda Mattingly 131
(a) Residence. No. Wilder, Ida R#1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E L Mattingly

6. DATE OF BIRTH (month, day and year) Jan 27 - 1862

7. AGE Years 68 Months 6 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER C. M. Simms
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) E L Mattingly Wilder, Idaho

15. Filed 8-21- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1928, to Aug 16 1930
that I last saw her alive on Aug 15 1930
and that death occurred, on the date stated above, at 10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bright's disease

(duration) 1 yrs. 11 mos. 25 ds.
CONTRIBUTORY (Secondary) Valvular Heart disease
(duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis? Lab.
(Signed) Robert E. Telbot M. D.
Aug 19 1930 (Address) Wilder Ida

19. Place of Burial, Cremation, or Removal Canyon Hill Date of Burial Aug. 18 1930
20. Undertaker C. V. Peckham Address Caldwell, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71659

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 99
(No. 133)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Maud Myrtle Howard

(a) Residence. No. 520 Elgin St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	0	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky.

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) J. A. Howard 520 Elgin Caldwell, Idaho

15. Filed 8-19- 1930. John S. Meyer - Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1930, to Aug 17 1930, that I last saw her alive on Aug 17 1930, and that death occurred, on the date stated above, at 6:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured Gall bladder
Myocarditis - with
anaemia -
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary) Carcinoma Gall bladder (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. D. Frazer M. D.
Aug 19 1930 (Address) Caldwell
1:30 Chapel

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Aug 19 1930
20. Undertaker C. W. Peckham	Address Caldwell Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71660

PLACE OF DEATH

County of Ada

City of Boise

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

Local Registrar's No. 100

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lauren Calaway Barnes

(a) Residence. No. Emmett Idaho St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 10 1914

7 AGE Years 16 Months - - Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmett Idaho

PARENTS

10 NAME OF FATHER N.B.Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mexico Mo.

12 MAIDEN NAME OF MOTHER Ellen Christine Tall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wyland Mo.

14 Informant Mr N B Barnes

(Address) Emmett Idaho

15 Filed 8-26, 1930. John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 18 1930 (Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930, to Aug 17, 1930 that I last saw him alive on Aug 17, 1930 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Appendicitis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Yes Date of Aug 17-1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gerald T. Nokes M. D.

....., 19..... (Address) Eastman Bldg Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Emmett Ida Cemetery

Date of Burial 8-19-30 19

20. Undertaker Paul L.Case

Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7166

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 10

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Carson Hopkins. 196

(a) Residence. No. Parma #1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 14-1903

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranching.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Castorville Missouri.

PARENTS

10. NAME OF FATHER C. J. Hopkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washburn Missouri.
12. MAIDEN NAME OF MOTHER Ethel Stubblefield.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Springfield Missouri.

14. Informant W V Hopkins
(Address) Parma #1

15. Filed 9-1, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 9-30a m.,
The CAUSE OF DEATH* was as follows:
Electrocuted. Accidental.

No inquest.

... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L Evans, M. D.
Aug 7-30, 19... (Address) Coroner Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell.	8/7 1930
20. Undertaker C. V. Beckham	Address Caldwell Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71663

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Dora Louise Roark

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, ~~Married, Widowed, or Divorced~~ (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 8-10-1930

7. AGE 0 Years 0 Months 0 Days If LESS than 1 day, 1 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~Housewife~~
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Ida

PARENTS
10. NAME OF FATHER Lonzo Roark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N Carolina
12. MAIDEN NAME OF MOTHER Viola Baldwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mrs A B Forrey
(Address) Kuna Ida

15. Filed 8-28, 1930 Roy Musselman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Aug 10, 1930
that I last saw her alive on Aug 10, 1930
and that death occurred, on the date stated above, at 8 30 a m.
The CAUSE OF DEATH* was as follows:
Mucus nasi latione during instrumental birth
(duration) one hour yrs. mos. ds.

CONTRIBUTORY (Secondary) No
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Beeramp M. D.
Aug. 10, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kuna
Date of Burial 8-10 1930

20. Undertaker —
Address —

RECEIVED AUG 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71663

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Kuna.
Registration District No. ____
Primary Registration District No. ____ Local Registrar's No. ____
(No. Kuna, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Mary A. Stanley

(a) Residence. No. ____ Kuna, Idaho. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Andrew Stanley.

6. DATE OF BIRTH (month, day and year) Sept. 17th 1889

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
40	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bates Co. Mo.

PARENTS
10. NAME OF FATHER S. King.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Sarah Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind,

14. Informant Andrew Stanley.
(Address) Kuna, Idaho.

15. Filed ____, 19____ ____ Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Nov 29, 1929, to Aug 7th, 1930
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at 11:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute dilatation of the heart

(duration) yrs. 8 mos. 21 ds.
CONTRIBUTORY (Secondary) Bronchitis —
(duration) yrs. 6 mos. — ds.

18. Where was disease contracted if not at place of death? At Kuna
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F J Coleman, M. D.
8/9/30, 19____ (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kuna Cemetery.	8/10/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Ada
~~City of~~ 10 mi. no. Nampa

Registration District No. 7
Primary Registration District No. 2006
(No. 10 mi. no. Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 103

48 B

2. FULL NAME Gideon J. Yoder
(a) Residence. No. 10 miles North Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ~~Fanny Yoder~~

6. DATE OF BIRTH (month, day and year) April 9th 1843

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
87	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS
10. NAME OF FATHER: Jacob Yoder
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Anna Yoder
13. BIRTHPLACE OF MOTHER (city or town) (State or County): unknown

14. Informant (Address): Miss Fannie Yoder Nampa, Idaho

15. Filed ..., 19.. Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 - 27 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1928, to 8-27, 1930
that I last saw him alive on 8-25, 1930
and that death occurred, on the date stated above, at 5:45 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed ~~diagnosis~~? ✓
(Signed) J. C. Horton, M. D.
8-28, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Boise Valley Cemetery
Date of Burial: 8-29 1930

20. Undertaker: Wm D. Falley
Address: Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ....., ... St.)

File No. 71665

Registered No. 102

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Don Humphry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nampa Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary Humphries

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Don Poynter

(Address) Nampa Idaho

15. Filed 8/27 1930 Bertha Conway
Local Registrar

MEDICAL CERTIFICATE OF DEATH

140

16. DATE OF DEATH: Aug (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-16- 1930, to 8-26- 1930 that I last saw him alive on 8-26- 1930 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Umbilical Hemorrhage (Bleeder)

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Don Poynter M. D.

..... 19..... (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. 10 days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem

DATE OF BURIAL: 8-28 1930

20. UNDERTAKER: F. K. Robinson

ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006 Local Registrar's No. 101
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Doris Ellen Smithey 11B
(a) Residence. No. R.F.D. No. 4 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 10 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 3rd 1925

7. AGE Years 5 Months — Days 23 If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS
10. NAME OF FATHER Frank E. Smithey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Clara Peters
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas

14. Informant (Address) Mrs. F. E. Smithey Nampa, Idaho

15. Filed 8-27, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Aug 25 1930, to ..., 19...
that I last saw her alive on Aug 25 1930
and that death occurred, on the date stated above, at 7 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Influenza

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) [illegible] M. D.
8-27, 19.. (Address) Nampa, Ida

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 8-28 1930

20. Undertaker Mrs. Nina M. Talley
Address Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7166

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 100
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susie Elizabeth Galloway 84
(a) Residence. No. 1123 - 4th St. North St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of S. E. Galloway

6. DATE OF BIRTH (month, day and year) March 16th 1870

7. AGE Years 60 Months 5 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER Wm Hales
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Mrs. Alma L. Johnson Boise, Idaho

15. Filed 8/23, 1930 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 18, 1930
that I last saw her alive on Aug 18, 1930
and that death occurred, on the date stated above, at 5:10 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Haemorrhage in brain
Progressive to a complete paralysis both sides.
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) High blood pressure Arteriosclerosis
Goiter (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P. Belknap, M. D.
Aug 18, 1930 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 8-24 1930

20. Undertaker Mrs. Nina M. Talley
Address Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7165

Local Registrar's No. 99

89

PLACE OF DEATH

County of Canyon

City of N. Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Cleveland Robinson

(a) Residence. No. 1317 4th St. South St.

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Effie Wyatt Robinson

6. DATE OF BIRTH (month, day and year) January 26, 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	6	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician & Surgeon

(b) General nature of industry, business, or establishment in which employed (or employer) Medical

(c) Name of employer self

9. BIRTHPLACE (city or town) (State or country) Amelia, Ohio - Clermont County

PARENTS

10. NAME OF FATHER Frank M. Robinson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ameiia Clermont County, Ohio

12. MAIDEN NAME OF MOTHER Phila Johnson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mt Washington Hamilton County, Ohio

14. Informant Stanley I. Robinson

(Address) Nampa - Idaho

15. Filed 8/22, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 20, 1930, that I last saw him alive on Aug 20 1930 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

c - acute Angina Pectoris

4 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

? (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. P. Foss, M. D.

Aug 21, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosedawn Cem	8/24 1930

20. Undertaker	Address
F. K. Robinson	Nampa & do

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED SEP 12 1930

DO NOT WRITE IN THIS SPACE
State File No. 71669

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 97
(No. 1 mile west Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard A. Pfeiffer 1489

(a) Residence. No. 216 - 16th Ave. So. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11th 1917

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) La grande Oregon

PARENTS

10. NAME OF FATHER G.W. Pfeiffer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Elizabeth Combs
13. BIRTHPLACE OF MOTHER (city or town) (State or County) W. Virginia

14. Informant G. W. Pfeiffer
(Address) Nampa, Idaho

15. Filed 8-8-30, 19.... Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12.30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Head & Chest crushed in water wheel—
Accidental—
No inquest

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Paul L. Case, M. D.
Coroner
8-8-30, 19.... (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 8-10 1930
20. Undertaker: Wm D. Talley. Nampa. Address: Ida.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7167

Local Registrar's No. 96

PLACE OF DEATH

County of Canyon

City of Nampa.

Registration District No. 7

Primary Registration District No. 1016

(No.) 162

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Elsie Cooke.

(a) Residence. No. 404 Holly. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1928-11-17.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	8	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa.

PARENTS

10. NAME OF FATHER V.H.Cooke.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.D.

12. MAIDEN NAME OF MOTHER MaryElla Maney.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant V.H, Cooke.
(Address) Nampa Ida

15. Filed 8-13, 1930 Della Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 - 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo G Mangum, M. D.

8-12, 1930 (Address) Nampa,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	8-1-30 19

20. Undertaker	Address
F.K.Robinson	Nampa Ida,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71671

PLACE OF DEATH
County of Canyon
City of

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 95
(No. near Melba)
(If death occurred in a hospital or institution, give its name instead of street and number.)

107

2. FULL NAME Billie Irvin Shryach
(a) Residence. No. near Melba St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 14th 1930
7. AGE Years Months Days If LESS than 1 day, 13 hrs. or 30 min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) near Melba
(State or country) Idaho.

PARENTS
10. NAME OF FATHER W. W. Shryach
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Urpha Marie Kelly
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) [illegible]

14. Informant (Address) W. W. S[illegible]
15. Filed 7-15, 1930 Beth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 14, 1930
that I last saw him alive on July 14, 1930
and that death occurred, on the date stated above, at 7:45 P.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
hungs never functioned properly & breathing irrigular Insplucation. Cured 12 hrs.
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Dry Birth, pressure & insplucation (duration) yrs. mos. 1 ds.
18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P. Behnap, M. D.
7-15, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal Kohlerlaun-Nampa
Date of Burial 7-15 1930
20. Undertaker Wm F. Talley
Address Nampa, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71673

PLACE OF DEATH

County of Canyon.

City of Nampa.

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 98

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME John Lynch

(a) Residence. No. 316 -10Ave. S. St. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan.1-1841.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
89	7	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work R.R. Employe.

(b). General nature of industry, business, or establishment in which employed (or employer) (Retired)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Wm Lynch

(Address) 316-10 ave South

15. Filed 8/11, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 8 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Natural Causes —
Old age —
No Inquest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No —

What test confirmed diagnosis?

(Signed) Paul L. Case, M. D. Coroner

8-8-1930, 19 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem.

Date of Burial: 8-11-30 19

20. Undertaker: F.K.Robinson.

Address: Nampa Ida.

Cole 7/5 30 8/12 Sam

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71673

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 101
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME John Frank Rowland
(a) Residence No. Cor Kim & Logan St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Geneva Rowland

6. DATE OF BIRTH (month, day and year) Feb. 26 - 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	5	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Owner of Service Station
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Locke
(State or country) Ohio

PARENTS
10. NAME OF FATHER James Rowland
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Sarah Oler
13. BIRTHPLACE OF MOTHER (city or town) Penn
(State or County)

14. Informant (Address) Clyde E. Rowland 611 Main Caldwell - Ida

15. Filed 8-23- 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 21, 1930
that I last saw him alive on Aug 20, 1930
and that death occurred, on the date stated above, at 2:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetes Millitus

(duration) Not known yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. W. Cole M. D.
8/22, 1930 (Address) Caldwell Ida
2:30

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Aug 22 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71674

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 102
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Edward Smith 44
(a) Residence. No. Parma #2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 25 - 1858

7. AGE: 71 Years, 11 Months, 27 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant M R Smith
(Address)

15. Filed 8-23-, 1930. John S. Meyer
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 22, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 4-30 P.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
..... (duration) 10 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A M. Mitchell M. D.
8/22, 1930 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Picabo Cem.
Date of Burial: 19

20. Undertaker: J. V. Peckham
Address: Caldwell Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71675

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 103
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. FULL NAME Jack Antonx Jontar

(a) Residence. No. Homedale Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 21 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	3 hrs.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Antonx Jontar
11. BIRTHPLACE OF FATHER (city or town) Scofield
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Josefshine Dolenc
13. BIRTHPLACE OF MOTHER (city or town) Rocksprings
(State or County) Wyo.

14. Informant Antonx Jontar
(Address) Homedale Idaho

15. Filed 8-23-, 1930 John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930 to Aug 22, 1930
that I last saw h[illegible] alive on Aug 21, 1930
and that death occurred, on the date stated above, at 7 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia Bilat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

8/22, 1930 (Signed) [illegible] M. D.
(Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	8-22-1930

20. Undertaker	Address
C. W. Peckham	Caldwell Ida

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71676

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 105
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME William Harvey Carlyle
(a) Residence. No. Parma, Ida (R#) St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs Callie A Carlyle

6. DATE OF BIRTH (month, day and year) Feb 11 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER Carlyle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Callie A. Carlyle Parma, Ida

15. Filed 8-27- 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1930, to Aug 25, 1930, that I last saw h~~im~~ alive on Aug 25, 1930, and that death occurred, on the date stated above, at 11:35 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic interstitial Nephritis and Chronic endocarditis
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature] M. D.
8/26, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Parma — Date of Burial: aug 28 1930
20. Undertaker: C. V. Peckham — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 3

DO NOT WRITE IN THIS SPACE
State File No. 71677

RECEIVED SEP 12 1930

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. .....
Primary Registration District No. 2005 Local Registrar's No 106
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49B

2. **FULL NAME** Julia Mary Emerson

(a) Residence. No. Caldwell RT 4 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
~~(or) WIFE~~ of Luther Emerson

6. DATE OF BIRTH (month, day and year) October 2 1863

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	10	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Oakhill
(State or country) Missouri

PARENTS

10. NAME OF FATHER Henry Steffer
11. BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or Country) Pa
12. MAIDEN NAME OF MOTHER Anna Pickering
13. BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or County) Pa

14. Informant M. R. Emerson
(Address) Caldwell Ida RT 4

15. Filed 8-28-1930 John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 27, 1930, to Aug 27, 1930
that I last saw her alive on Aug 27, 1930
and that death occurred, on the date stated above, at 9:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis —
.....
.....
.....(duration) .....yrs. .....mos. 1/2 ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical

(Signed) W. D. Payne, M. D.
Aug 28, 1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	8-31 1930
20. Undertaker C. N. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 107
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Martin
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 8-27-30

7. AGE — Years — Months — Days 1 If LESS than 1 day, 4 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER Chas Martin
11. BIRTHPLACE OF FATHER (city or town) Aberdeen So. Dak.
(State or Country)
12. MAIDEN NAME OF MOTHER Allie Fay Mesler
13. BIRTHPLACE OF MOTHER (city or town) Verdun Nebr
(State or County)

14. Informant (Address) Chas Martin Caldwell Ida

15. Filed 8-28-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8-28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1930, to Aug. 28, 1930
that I last saw her alive on Aug. 27, 1930
and that death occurred, on the date stated above, at 24 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature
6 mo.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) David E Baird, M. D.
Aug 28, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 8-29 1930

20. Undertaker: Paul L Case
Address: Caldwell Idaho

Aug. 21 – 30

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71679

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 108
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

185

2. FULL NAME John Alfred Saleen

(a) Residence. No. Emmett, Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND ~~of~~
~~(or) WIFE~~ of Edris Saleen.

6. DATE OF BIRTH (month, day and year) June 11- 1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lineman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10. NAME OF FATHER Saleen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Anna Peterson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) France

14. Informant (Address) Mrs Saleen Emmett, Idaho

15. Filed 9-3- 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1930, to Aug 30 1930, that I last saw h~~im~~er alive on Aug 30 1930, and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Compound fracture of leg, Caused by falling with power line pole, Gen. bacillus infection
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Caldwell
Did an operation precede death? Yes Date of Aug 28
Was there an autopsy? Yes
What test confirmed diagnosis? Symptoms
(Signed) J. W. Call M. D.
9/2 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett, Ida	9-3- 1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

cole

June 27-5

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71680

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 9005 Local Registrar's No. 109
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Marion Vasser

(a) Residence. No. Caldwell, Ida. R.F.D. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

48a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 13- 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	4	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Olathia
(State or country) Kansas

PARENTS

10. NAME OF FATHER John R Vasser
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Martha Dogrig
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant S H Vasser
(Address) Caldwell Idaho

15. Filed 9-3- 1930. John S Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1930, to Aug 30 1930, that I last saw h[illegible] alive on Aug 29 1930 and that death occurred, on the date stated above, at 1:45a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
with Congestion of kidneys
(duration) about yrs. mos. ds.
CONTRIBUTORY (Secondary) Cancer
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [illegible] M.D.
Sept 2 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: 8-31- 1930
20. Undertaker: C. V. Peckham — Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 110
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Ed. B. Downey
(a) Residence. No. Caldwell R.D. #4 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of — —

6. DATE OF BIRTH (month, day and year) Jan-3-1854

7. AGE Years: 76 Months: 8 Days: 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: ranching
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Edina Missouri

PARENTS

10. NAME OF FATHER: Joseph Downey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dublin Ireland
12. MAIDEN NAME OF MOTHER: Susan Tomlinson
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Lewisville Kentucky

14. Informant (Address): Mrs L M Shafer Caldwell Ida

15. Filed 9-6-, 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) - 4 - (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3.30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gunshot wound in head.
Suicide. No inquest.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Paul L. Case, M. D.
9-5-30, 19..... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 9-6 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

CERTIFICATE OF DEATH 3

County of Caldwell
City of Canyon
Registration District No. .....
Primary Registration District No. 1005
Local Registrar's No. 111
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George Nicholas Sedlmayer - 1/2

(a) Residence. No. 1006 Belmont, Caldwell
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married.

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) Dec-30-1887

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	8	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. Assistant Engr ~~Flour~~ Mills
(b) General nature of industry, business, or establishment in which employed (or employer) Flour
(c) Name of employer

9. BIRTHPLACE (city or town) Mancato
(State or country) Minnesota

PARENTS

10. NAME OF FATHER George Sedlmayer Sr.
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Germany.
12. MAIDEN NAME OF MOTHER [illegible]
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) [illegible]

14. Informant (Address) Mrs George Sedlmayer 1006 Belmont Caldwell Ida

15. Filed 9-6 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Sept 5, 1930
that I last saw h~~im~~ alive on Sept 5, 1930
and that death occurred, on the date stated above, at 2-P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) ..... yrs. mos. 29 ds.
CONTRIBUTORY (Secondary) Ruptured Appendix
(duration) ..... yrs. mos. 29 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Aug 7 30
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.
9/6, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Denver, Colo. — Date of Burial: 9-7-1930
20. Undertaker: C. V. Packham — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71683

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 112
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh S. Travis 31
(a) Residence. No. 320 Cleve Caldwell Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) Mch 19-1882

7. AGE Years 48 Months 5 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) ~~Iola~~ Piqua
(State or country) Woodson Co. Kansas.

PARENTS
10. NAME OF FATHER Calvin M. Travis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Matilda Edder
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant (Address) Alma E. Travis. Homedale

15. Filed 9-9- 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 24, 1930, to Sept 7, 1930
that I last saw him alive on Sept 7, 1930
and that death occurred, on the date stated above, at 6 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Flu Pneumonia
(duration) yrs. 8 mos. ds.

18. Where was disease contracted if not at place of death? Homedale Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? X Ray Chest
(Signed) P. D. Farrar M. D.
Sept 8, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal Canyon Hill. Date of Burial 9-9 1930
20. Undertaker C. V. Peckham Address Caldwell Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 113
(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Virgil Dean Henson

(a) Residence. No. Rt 5 Nampa, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rt 5 Nampa
(State or country)

PARENTS

10. NAME OF FATHER Samuel A. Henson

11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Gussie Orr

13. BIRTHPLACE OF MOTHER (city or town) Montana
(State or County)

14. Informant (Address) Gussie Henson
Gussie Henson Nampa

15. Filed 9-8-, 1930. John S. Meyer, Registrar.
R. 5.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Sept 8, 1930
that I last saw him alive on Sept 8th, 1930
and that death occurred, on the date stated above, at 9 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ileo Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
9/8, 1930 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	9-10-30 19

20. Undertaker	Address
P. L. Case	Caldwell

Haley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71685

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 114
(No.) 48B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Julia Rebeccah Shields
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 9th 1876
7. AGE Years: 53 Months: 10 Days: 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS
10. NAME OF FATHER: John Myers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ~~Not~~ Kentucky
12. MAIDEN NAME OF MOTHER: Mary Spears
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ill

14. Informant (Address): B. Grace Frost city

15. Filed 9-10- 1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept. 8, 1930
that I last saw her alive on Sept. 8, 1930
and that death occurred, on the date stated above, at 8:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchiectasis Nephritis
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) [signature], M. D.
9-8- 1930 (Address) Caldwell Id

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 9-10 1930

20. Undertaker: C. V. Peckham
Address: Caldwell, Id

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71687

REC'D AUG 23 1930

PLACE OF DEATH

County of Cassia
City of Burley
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Cassius M Clay Buchanan 70

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret M Buchanan

6. DATE OF BIRTH (month, day and year) Mar 5 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	4	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Doctor
(b) General nature of industry, business, or establishment in which employed (or employer) M. D.
(c) Name of employer

9. BIRTHPLACE (city or town) Moscow
(State or country) Ohio

PARENTS

10. NAME OF FATHER Samuel Buchanan
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Nancy Simmons
13. BIRTHPLACE OF MOTHER (city or town) Batavia
(State or Country) Ohio

14. Informant Margaret Buchanan
(Address) Burley Idaho

15. Filed 8-20-, 1930 F. H. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 26, 1930
that I last saw him alive on July 26, 1930
and that death occurred, on the date stated above, at 9 PM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Ca. Duls
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean M. D.
July 29 1930 (Address) Burley, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Burley Ida	
20. Undertaker W. C. Johnson	Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71C[illegible]

PLACE OF DEATH

County of .....

City of .....

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Charles Cushion Allen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 14, 1929

7. AGE Years 1 Months 2 Days 3 If [illegible] than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER James B Allen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Alice Cushion

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) J B Allen Burley Idaho

15. Filed ....., 19.... ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930 to July 19, 1930

that I last saw him alive on July 18, 1930

and that death occurred, on the date stated above, at 4 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchitis

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) G. H. Cooper, M. D.

July 23 1930 (Address) Burley Idg

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial July 19 1930

20. Undertaker D. E. Johnson — Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7100

PLACE OF DEATH

County of Minidoka
City of Rupert

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

144

2. FULL NAME Julia Maria McBride

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William McBride

6. DATE OF BIRTH (month, day and year) Feb.4 1890

7. AGE Years 40 Months 5 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Oakley
(State or country) Idaho

PARENTS

10. NAME OF FATHER John L Smith
11. BIRTHPLACE OF FATHER (city or town) Salt Lake City
(State or Country) Utah
12. MAIDEN NAME OF MOTHER Julia Haight
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant John L Smith
(Address) Oakley Ida

15. Filed ....., 19.....
F. H. Cutler
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 11 1930 (Month) (Day) (Year), 19.....

17. I HEREBY CERTIFY, That I attended deceased from May 25, 1930, to July 11, 1930
that I last saw her alive on July 11, 1930
and that death occurred, on the date stated above, at 12 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lymphatic Septicaemia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Confinement

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) F. H. Cutler, M. D.
July 13, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal Oakley Ida
Date of Burial July 13 1930

20. Undertaker D. E. Johnson
Address Burley

RECEIVED SEP 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7100

PLACE OF DEATH
County of Clark
City of Idmon
Registration District No. 123
Primary Registration District No. 2203
Local Registrar's No.
(No. 197)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lawrence Vadnais

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 18 1907

7. AGE — Years: 22 — Months: 11 — Days: 23 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idmon

PARENTS

10. NAME OF FATHER: Ludgar Vadnais
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Kelly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Ludgar Vadnais
(Address) Idmon Idaho

15. Filed Aug 13, 1930 C E Jones MD Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 1 a m.

The CAUSE OF DEATH* was as follows:

Rifle shot in head - homicide

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C E Jones M. D.
Aug 13, 1930 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idmon Idaho — Date of Burial: 8/13 1930

20. Undertaker: V J McHan — Address: Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71099

PLACE OF DEATH
County of Clark
City of Heemphrey

Registration District No. 125
Primary Registration District No. 2203
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

204

2. FULL NAME Thomas Wesley Rose

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 19 1852

7. AGE Years 78 Months 4 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER Wesley Rose
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Mariah Gates
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant E J Rose
(Address) Lima Montana

15. Filed Aug 10, 1930 C E Jones MD Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:
General debility - sudden death
..... (duration) 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Heart Complication
..... (duration) ..... yrs. 6 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C E Jones, M. D.
Aug 10, 1930 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rigby Idaho | Date of Burial Aug 11 1930

20. Undertaker F McHan | Address Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 4 1930

RECEIVED DEC 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71[illegible]

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 62

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Estal Armstrong

(a) Residence. No. ..... St. Pittsboro, Indiana
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, ~~Married,~~ Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day,
22	7	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pittsboro, Indiana

PARENTS

10. NAME OF FATHER: Orse Armstrong

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Pittsboro, Indiana

12. MAIDEN NAME OF MOTHER: Mary Carver

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Salem Indiana

14. Informant: [illegible]
(Address) Orofino Idaho

15. Filed 8/30, 19.. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 4:[illegible] m.

The CAUSE OF DEATH* was as follows:

Accidental drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. T. Hopkins M. D.

8/30/30, 19.. (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pittsboro, Indiana

Date of Burial: 19

20. Undertaker: W. A. Shaw

Address: Orofino

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7169

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 2187
Primary Registration District No. 90
Local Registrar's No. 61

(No.) 95
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert E. Simmonds

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed 8/25, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Just one call 19..., to 8-25-, 1930
that I last saw him alive on 8-25, 1930
and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH* was as follows:
Probably Haemorrhage
few minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis & Epilepsy
(duration) Don't Know yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not Known
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms & Contusion
(Signed) W. Robertson, M. D.
Aug 26, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	8/27 19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71695

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 2147
Primary Registration District No. 90

Local Registrar's No. 60

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Chas H. Mason

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 9 1842

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88-			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS
10. NAME OF FATHER ~
11. BIRTHPLACE OF FATHER (city or town) ~
(State or Country)
12. MAIDEN NAME OF MOTHER ~
13. BIRTHPLACE OF MOTHER (city or town) ~
(State or Country)

14. Informant Paul Bastin
(Address) Orofino

15. Filed 8/25, 1930 H. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Aug 24, 1930
that I last saw him alive on Aug 24, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration Unknown yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) D. J. Hopkins, M. D.
8/25, 1930 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	8/26 1930
20. Undertaker	Address
H. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7166

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 96
Primary Registration District No. 2197
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 59

31

2. FULL NAME Bernard Hoiseth

(a) Residence. No. ..... St. Kootenai, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unascertained

PARENTS
10. NAME OF FATHER Halvor Hoiseth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Helga Viberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Records, Northern Idaho Sanitaium,
(Address) Orofino, Idaho

15. Filed 9/21, 19.... H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 28, 1929, to Aug. 19, 1930
that I last saw him alive on August 19, 1930
and that death occurred, on the date stated above, at 12.20 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Dementia praecox, paranoid type (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
August 19, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Aug 21 1930
20. Undertaker W. D. Pinson	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7102

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 58

74A

2. FULL NAME Sophia Watson

(a) Residence. No. ..... St. Cotonwood, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 9/12, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
May 1 - 1926 to August 10, 1930
that I last saw her alive on August 10 1930
and that death occurred, on the date stated above, at 10:25 A. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage (apoplexy).
(duration) 0 yrs. 0 mos. 7 ds.
CONTRIBUTORY (Secondary) Dementia praecox, paranoid type
(duration) 35 yrs. + mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine Mileaway M. D.
August 10, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho Sanitarium Cemetery	Aug. 11 1930
20. Undertaker	**Address**
F. A. Billberg - Hosp. Attd.	Orofino - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71608

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 57
(No. Northern Idaho Sanitarium) 74
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert E. Pfiffner

(a) Residence. No. ..... St. Ferdinand, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? 21 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Pfiffner

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mels, Switzerland

PARENTS

10. NAME OF FATHER Joseph Pfiffner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho

15. Filed 9/10, 19.... H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to August 10, 1930
that I last saw him alive on August 9, 1930
and that death occurred, on the date stated above, at 2.15 A. m.
The CAUSE OF DEATH* was as follows:

Status epilepticus

(duration) 0 yrs. 0 mos. 7 ds.
CONTRIBUTORY (Secondary) Psychosis with epilepsy -
(duration) 4 yrs. 8 mos. 0 ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M.D.
August 10, 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ferdinand Ida	9/11 19
20. Undertaker	Address
H. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7169

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 56

34

2. FULL NAME Elsie Benoy

(a) Residence. No. ..... St. Stites, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 19 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Umatilla, Oregon

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15. Filed 8/5, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to August 1, 1930
that I last saw her alive on August 1, 1930
and that death occurred, on the date stated above, at 11.15 A m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal syphilis

(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis with cerebro-spinal syphilis (duration) 20 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis? Physical signs

(Signed) John Grover McKelvey, M. D.
August 1, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
N. I. Sanitarium Cemetery	August 2 1930
20. Undertaker	Address
E. A. Bielberg, Hosp. attd.	Orofino, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71700

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

188a

2. FULL NAME Thomas E. Pack

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: M
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 10. 1867

7. AGE Years 63 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant G. M. Shearer
(Address) Everett Ida

15. Filed 8/4, 19.. W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to Aug. 3, 1930
that I last saw him alive on ~~July 31~~ Aug 3, 1930
and that death occurred, on the date stated above, at 8:45 a m.
The CAUSE OF DEATH* was as follows:
Punctured wound lung, shock, fractures and rib, clavicle (rt) lower jaw - accident railroad wreck (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R. J. Hopkins, M. D.
8/4/30 19.. (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Ida | Date of Burial: 8/4 19

20. Undertaker: W. A. Shaw | Address: Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7170

PLACE OF DEATH
County of Custer
City of Mackay

Registration District No. 76
Primary Registration District No. 2153
Local Registrar's No. 136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Chris Rogers
(a) Residence. No. Mackay, Ida St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word) widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Rogers

6. DATE OF BIRTH (month, day and year) 12-26-1840

7. AGE 90 Years | Months 7 | Days 10 | If LESS than 1 day, 2 hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) Troy Smith

15. Filed Sept. 4, 1930. Rose Nowacki Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8- (Month) 6 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1930, to 8-5-, 1930
that I last saw him alive on 8-5-30, 19....
and that death occurred, on the date stated above, at 2:15 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach and Liver.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? yes
What test confirmed diagnosis? .....
(Signed) Carlos A. Jensen, M. D.
....., 19.... (Address) Mackay Ida

19. Place of Burial, Cremation, or Removal: Houston Cemetery Mackay
Date of Burial: 8-8 1930

20. Undertaker: Geo. R. Garnier
Address

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71702

PLACE OF DEATH
County of Custer
City of Near Grouse, Ida.

Registration District No. 16
Primary Registration District No. 2153
Local Registrar's No. 135
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

114

2. FULL NAME Harold S. Taylor

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: wt
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Dec. 9. 1917

7. AGE

Years	Months	Days	If LESS than 1 day,
13	7	10	6 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mackay, Ida.

PARENTS

10. NAME OF FATHER Amos S. Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grouse Idaho
12. MAIDEN NAME OF MOTHER Ethel May Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Helena Montana

14. Informant (Address) X Bryan E. Taylor

15. Filed Sept. 4, 1930 Rose Nowacki Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-15, 1930, to 7-19, 1930
that I last saw him alive on 7-16-30, 19....
and that death occurred, on the date stated above, at 11:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Enteritis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? zero Date of .....
Was there an autopsy? zero
What test confirmed diagnosis? .....
(Signed) Carroll A. B. Swain, M. D.
7-19, 1930 (Address) Thorby Ida

19. Place of Burial, Cremation, or Removal: Mt McCalif. Mackay
Date of Burial: July 21 1930

20. Undertaker: Theo. R. Garnier
Address: Mackay, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71703

PLACE OF DEATH
County of Elmore
City of Glennis Ferry

Registration District No. 35
Primary Registration District No. 2021
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

188 e

2. FULL NAME Mrs Mary Ann Sinnott
(a) Residence. No. Sierra Madre California
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence C Sinnott

6. DATE OF BIRTH (month, day and year) —

7. AGE: Years about 55; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Lenahan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Catherine Sinnott
(Address) Sierra Madre Calif

15. Filed Sept 1, 1930 Mrs Mary L. Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug 27, 1930
that I last saw her alive on Aug 27, 1930
and that death occurred, on the date stated above, at 9 30 P. m.
The CAUSE OF DEATH* was as follows: auto accident - Head on collision between two cars
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Dr. J W Davis, M. D.
Sept 1, 1930 (Address) Glennis Ferry
G C Zacher Coroner 8-30-30

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
Elmore Co Mountain Home Ida

19. Place of Burial, ~~Cremation~~, or Removal: Sierra Madre Calif
Date of ~~Burial~~ Shipping: 9-1-30

20. Undertaker: G C Zacher
Address: Mt Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71701

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

44

2. FULL NAME Benjamin Alvin Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 29 1870

7. AGE Years 60 Months 3 I Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheep and farm work
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweeden

PARENTS

10. NAME OF FATHER: Laes Benson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER: Johanna Benson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweeden

14. Informant: Mrs Geo Gill
(Address) Preston Idaho

15. Filed 9/3/30, 19.... A. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-1, 1930, to 8-30, 1930
that I last saw him alive on 8-26, 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomack
..... (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. R. Cutler, M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dayton Idaho
Date of Burial: Sept 2 30 19

20. Undertaker: W M Hendricks
Address: Preston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71705

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Lena P Crockett

(a) Residence. No. Preston Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin A. Crockett

6. DATE OF BIRTH (month, day and year) May 12 1885

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Idaho

PARENTS

10. NAME OF FATHER Soren J. Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Louise Sponberg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Franklin

14. Informant Edwin A. Crockett
(Address) Preston

15. Filed 9/3/30, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug — 29 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 -, 1930, to Aug 29, 1930
that I last saw her alive on Aug 29, 1930
and that death occurred, on the date stated above, at 4:55 p m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) — yrs. — mos. 1/4 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis -
(duration) 10 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. Staley M. D.
Aug 30, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Sept 1 1930

20. Undertaker M. W. Hendricks Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71706

PLACE OF DEATH
County of Fremont
City of Felon

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 348

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vera Ann Siddoway

(a) Residence. No. 41 St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug. 26-1930

7. AGE — Years | Months | Days: | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Felon Idaho

PARENTS

10. NAME OF FATHER: Kenneth Siddaway
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Felon Idaho
12. MAIDEN NAME OF MOTHER: Emma M. Aldridge
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Malad Idaho

14. Informant: Kenneth Siddoway
(Address): Felon Idaho

15. Filed Sept 6, 1930 W. H. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930, to Sept. 6, 1930
that I last saw her alive on Sept. 5, 1930
and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:
Insanitis,
Septicemia, secondary.
Secondary Anemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R. B. Rigby, M. D.
Sept 6, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Felon — Date of Burial: Sept. 7 1930

20. Undertaker: W. H. Hansen — Address: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71707

PLACE OF DEATH
County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ~~348~~ 347

2. FULL NAME Martha Jane Rice.

(a) Residence. No. ..... St. 88a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 21, 1857.

7. AGE Years 73. Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home.
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sanbarndino. Calif.

PARENTS

10. NAME OF FATHER Arvin Stoddard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not-Known.
12. MAIDEN NAME OF MOTHER Caroline Sargent.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant St. Anthony Ida.
(Address) Caroline Workman

15. Filed Aug, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 22, 1930
that I last saw her alive on July 22, 1930
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis and Myocarditis.
..... (duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) T A Ellison, M. D.
Aug 29, 1930 (Address) St. Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Parker Cemetery
Date of Burial: Aug 30 1930.

20. Undertaker: Vern J Keller.
Address: Rexburg

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71705

PLACE OF DEATH
County of Fremont
City of New-Dale
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 346

(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Heber Clarence Robinson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Maud Clarice Johnson

6. DATE OF BIRTH (month, day and year) June 2nd-1888

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	2	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grantsville-Utah

PARENTS

10. NAME OF FATHER H. J. Robinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Jane L. Millward
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Aldo Barrus
(Address) Sugar City

15. Filed Aug 12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1930, to Aug 11, 1930
that I last saw him alive on Aug 11, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows
22 rifle gun shot wound
abdomen (Self inflicted)
(Hemorrhage & shock)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
Aug 12, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
New Dale-Cematery	Aug. 13th 1930
20. Undertaker: Alvin Keller	Address: Rexburg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71709

PLACE OF DEATH

County of Fremont
City of Teton
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 345
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lelia Bell Thomson

(a) Residence. No. Teton City, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 15-1908

7. AGE	Years	Months	Days	If LESS than 1 day,
	22	4	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Teton, Idaho.

PARENTS

10. NAME OF FATHER Robert Thomson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah
12. MAIDEN NAME OF MOTHER Josephine Pincock
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogedn, Utah.

14. Informant Mrs Robert Thomson
(Address) Teton, Idaho

15. Filed Aug 4, 1930 W. H. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 1st, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1924, to Aug 1, 1930
that I last saw h[illegible] alive on July 30, 1930
and that death occurred, on the date stated above, at 5:15 P m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) Louis S. Rich, M. D.
Aug. 4th, 1930 (Address) Rexburg, Idaho

(*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teton Cemetery	Aug. 5-1930
20. Undertaker W. H. Hansen	Address St. Anthony, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 15 1930

PLACE OF DEATH

County of Fremont

City of St. Anthony

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

(No.) 48 B

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 7171

Local Registrar's No. 344

2. FULL NAME Rhoda Bessie Reynolds

(a) Residence. No. St. Anthony, Idaho. R. F. D. 1 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 13th, 1914

7. AGE	Years	Months	Days	If LESS than 1 day,
	16	2	13	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) St. Anthony, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER James J. Reynolds

11. BIRTHPLACE OF FATHER (city or town) Muskitine, Iowa
(State or Country)

12. MAIDEN NAME OF MOTHER Chloe Thompson

13. BIRTHPLACE OF MOTHER (city or town) St. Anthony, Idaho.
(State or Country)

14. Informant Mrs Chloe Reynolds
(Address) St. Anthony Idaho R.F.D.#1

15. Filed July 27th, 1930 H. M. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 27th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11, 1930, to July 27, 1930
that I last saw her alive on July 27, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows: Acute Myocarditis
Serologic Lab. report neg. for typhoid.
Well water Lab. report positive for
sewage contamination. Clinically resembled
typhoid (duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Pneumonitis.
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? See above.

(Signed) T. A. Ellison, M. D.

July 29-1930 (Address) St. Anthony. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilford Cemetery	July 29-1930

20. Undertaker H. M. Hansen Address St. Anthony Ida

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71711

PLACE OF DEATH
County of Fremont
City of St Anthony

Registration District No. 99
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ~~344~~ 343

101a

2. FULL NAME Nickie Olene Johnson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3rd 1930

7. AGE: X Years | X Months | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Anthony Ida

PARENTS

10. NAME OF FATHER Robert C Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boise Ida
12. MAIDEN NAME OF MOTHER Hazel Jacobs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska

14. Informant Robert C. Johnson
(Address) St Anthony

15. Filed July 22, 1930 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 21, 1930
that I last saw him alive on July 21, 1930
and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Whooping Cough.
..... (duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Coughing & Lung Consol
(Signed) P. M. Kelly, M. D.
July 21, 1930 (Address) St Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Anthony Idaho
Date of Burial: July 23 1930

20. Undertaker: Wm. J. Kelly
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT REC[illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible]TION is very important. See instruction on back of certificate.

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7171

PLACE OF DEATH

County of Fremont
City of St. Anthony
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 342
(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Kenney Worrell

(a) Residence. No. R. F. D. # 2 St. Anthony, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20-1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	1	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Thadenes Worrell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Nancy Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant P. P. Worrell
(Address) Chester, Idaho.

15. Filed July 18-1930 W. M. Hansen Registrar W. M. Hansen

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to July 17, 1930
that I last saw him alive on July 13, 1930
and that death occurred, on the date stated above, at 4:30 a. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Findings

(Signed) P. M. Kelly, M. D.
July 19-1930 (Address) St. Anthony. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilford Cemetery	July 20-1930

20. Undertaker	Address
W. M. Hansen	St. Anthony, Iddaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71714

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74B

2. FULL NAME Nancy Jane Wise
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: G. W. Wise

6. DATE OF BIRTH (month, day and year): May 19, 1845

7. AGE: Years 85 | Months 9 | Days 2 | If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS

10. NAME OF FATHER: Joel Malicoat
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Tenn.

14. Informant (Address): J. L. Wise.

15. Filed Aug 19, 1930 J. T. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Aug 5, 1930, to Aug 17, 1930
that I last saw her alive on Aug 12, 1930
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATUPE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral thrombosis

.....(duration) .....yrs. .....mos. 12 ds.
CONTRIBUTORY (Secondary) arterio sclerosis
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. D. Buckmaster M. D.
8-19-, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: Aug 20 1930
20. Undertaker: C. D. Buckmaster — Address: Emmett Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. .....
Primary Registration District No. 6 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Dama Chandler
(a) Residence. No. 512 E. Second St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Cutler Chandler

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Hartford
(State or country) Wisconsin

PARENTS
10. NAME OF FATHER Silas Grover
11. BIRTHPLACE OF FATHER (city or town) Utica
(State or Country) New York State
12. MAIDEN NAME OF MOTHER Dama Grover
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) New Hampshire

14. Informant (Address) Daisy L. Chandler 512 E. Sec. St.

15. Filed Aug 14, 1930 J. L. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1928, to Aug 9, 1930
that I last saw her alive on Aug 9, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
arterio-sclerosis

several (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. N. [illegible] M. D.
8-14-1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal Emmett
Date of Burial Aug 15 1930

20. Undertaker C. D. Bucknum
Address Emmett Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 717

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Gem
City of Emmett
Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie A Callander 49

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 28 yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of S. B. Callander

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	4	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10. NAME OF FATHER John Peckdark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Holland.

14. Informant Mrs Grace Atkin
(Address) .....

15. Filed Aug 14, 1930. J. L. Seymour Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 12, 1930, that I last saw her alive on Aug 12, 1930 and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina Pectoris -
1-hr
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) R. M. Cummings M. D.
8-14-, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal Emmett — Date of Burial Aug 15 1930

20. Undertaker C. D. Buckmaster — Address Emmett Idaho.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED SEP 6 1930

DO NOT WRITE IN THIS SPACE

State File No. 7171

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

19 S

2. FULL NAME Arbon R. Heap

(a) Residence. No. Emmett Idaho St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	11	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Arbon Heap

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Stevens

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Artella Barr

15. Filed Aug. 8, 1930 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 4th (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Aug 4, 1930.

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Electrocuted by a bolt of lightning

(duration) ..... yrs. ..... mos. 0 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) R. R. Cummings M. D.

8-8-, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	Aug 10, 1930
20. Undertaker	Address
C. D. Bucknum	Emmett Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 6 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No.

(No. ..... St.)

File No. 71719

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stevie Feaster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 4 (Day) 1867 (Year)

7. AGE 63 Yrs. 5 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) ~~Missouri~~ Virginia

10. NAME OF FATHER William A. Aven

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Sarah J. Henshaw

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H B Kern

(Address) Bingham Canyon Utah

15. Filed 8/5 1930 J L Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Aug (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1930, to Aug 4th 1930, that I last saw her alive on Aug 3rd 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexia. Hemoplegia

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration Several Yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.

8/5 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho

DATE OF BURIAL: 8/6 1930

20. UNDERTAKER: C D Buckmann

ADDRESS: Emmett Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. .....

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John Yates

(a) Residence No. ..... St. .....
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Pearl Yates

6. DATE OF BIRTH (month, day and year) June 16 - 1874

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	2	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Little Rock (State or country) Ark

PARENTS

10. NAME OF FATHER S. N. Yates

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Eliza Cashmead

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo

14. Informant (Address) D. L. Yates

15. Filed 9/23, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
Aug 7, 1930, to Aug 21, 1930
that I last saw him alive on Aug 21, 1930
and that death occurred, on the date stated above, at 4. a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dropsy & Heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? don't know
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? general appearance

(Signed) as a friend A M Wilt M.D.
9/23, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 8/24 1930

20. Undertaker: O D Buckner — Address: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71720

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Gooding

City of Gooding

Registration District No. 24

Primary Registration District No.

(No.)

Local Registrar's No. 135

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ira P. Tarpning

90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Glenna Tarpning

6 DATE OF BIRTH (month, day and year): Nov. 16 - 1843

7 AGE: Years 86 | Months 8 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): farmer

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Union Co. Ohio

PARENTS

10 NAME OF FATHER: Loren Tarpning

11 BIRTHPLACE OF FATHER (city or town) (State or country): dont know

12 MAIDEN NAME OF MOTHER: dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): dont know

14 Informant: Frank Tarpning

(Address): Gooding Ida.

15 Filed 8-13, 1930 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: August (Month) 12 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1927, 19, to Aug 12, 1930, that I last saw him alive on Aug 5, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio-scleroses

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Gooding Ida

Date of Burial: 8-13 1930

20. Undertaker: A. E. Thompson

Address: Gooding

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7172

PLACE OF DEATH
County of Gooding
City of Wendell

Registration District No. 22
Primary Registration District No. 2018
Local Registrar's No.

(No. at home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 a

2. FULL NAME William E. Rippleye
(a) Residence. No. Wendell R.F.D. #2 St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Carrie Rippleye

6. DATE OF BIRTH (month, day and year) Feb. 24 1887

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arizona

PARENTS
10. NAME OF FATHER David F. Rippleye
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Laura E. Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. Wm E. Rappleye
(Address) Wendell R.F.D. #2

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26, 1930, to May 30, 1930
that I last saw him alive on May 30 1930
and that death occurred, on the date stated above, at 12 noon m.
The CAUSE OF DEATH* was as follows: Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) O. L. Dimonton M. D.
May 31, 1930 (Address) Wendell

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	June 2 1930
20. Undertaker	Address
J. F. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19 RECEIVED SEP 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22

Primary Registration District No. 2018.

(No. ..... St.)

File No. [illegible]

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Edward Potter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 7" (Day) 1850 (Year)

7. AGE: 79 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: George Potter

11. BIRTHPLACE OF FATHER (State or Country): in U. S.

12. MAIDEN NAME OF MOTHER: Susan Allison

13. BIRTHPLACE OF MOTHER (State or Country): in U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie M. Crouse

(Address) Wendell Idaho

15. Filed May 18 1930 E. L. Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1930, to May 17 1930 that I last saw him alive on May 17 1930 and that death occurred on the date stated above, at 7 30 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia for Bronchitis and general debility

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) General debility & senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Simonton M. D.

..... 19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida

DATE OF BURIAL: May 19 1930

20. UNDERTAKER: Tompson Furniture Co

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-2[illegible] RECEIVED SEP 2 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Wendell

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22.

Primary Registration District No. 2019.

(No. ..... St.)

File No. [illegible]

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alvin B. Roberts.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 24 (Day) 1859 (Year)

7. AGE: 71 Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: A.B. Roberts

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry Roberts.

(Address) Jerome Idaho

15. Filed July 9 1930 E L Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

49

16. DATE OF DEATH: July (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Home necessary disease 19 to that I last saw h..... alive on ..... 19 ..... and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Hisson - Perry Roberts reports that he died of cancer of the face -

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Simonton M. D.

..... 19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removal to Twin

DATE OF BURIAL: 7-9 1930

20. ~~UNDERTAKER~~

ADDRESS: Wendell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Idaho
City of Grangeville

CERTIFICATE OF DEATH
Registration District No. 103
Primary Registration District No. 2181 Local Registrar's No. 21
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mamie Lowther
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 31, 1844
7. AGE Years 85 Months 7 Days 27 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Richard to West Virginia

PARENTS
10. NAME OF FATHER Jassie M Lowther
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER F Hall
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) [illegible] Grangeville
15. Filed 9-1- 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 27 (Day) 19 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1929, to June 15, 1930
that I last saw him alive on June 15, 1930
and that death occurred, on the date stated above, at m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows: Chronic Interstitial Nephritis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary findings
(Signed) B. Chipman, M. D.
8-29, 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal Denver Idaho
Date of Burial 8-29- 1930
20. Undertaker Hancock Und. Co
Address Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 4 193(

PLACE OF DEATH

County of Idaho

City of Adams Twp

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 103

Primary Registration District No. 2181

DO NOT WRITE IN THIS SPACE

State File No. 71727

Local Registrar's No. 20

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1918

2. FULL NAME James Wisenor

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Estella Wisenor

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 68 | Months: July 4 | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ranches

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Arkansas

PARENTS

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: Clay Davis

(Address) Lucile Idaho.

15. Filed 9-1-, 1930 B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21 (Month) 11 (Day) 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1929, to Jan 12, 1930

that I last saw him alive on Jan 12, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows: Chronic Myocarditis

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Cardiac Findings

(Signed) B Chipman M. D.

8-23-, 1930 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Whitebird Ida. — Date of Burial: 8-23-1930

20. Undertaker: Duncan Mtg. Co — Address: Grangeville

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Idaho
City of Grangeville

CERTIFICATE OF DEATH

Registration District No. 103
Primary Registration District No. 2181 Local Registrar's No. 19
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jesse Isaac Holingshed 187

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lila Holingshed

6. DATE OF BIRTH (month, day and year): Dec. 13, 1873

7. AGE: Years 56 | Months 7 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denton County Arkansas

PARENTS

10. NAME OF FATHER: Jesse Isaac Holingshed
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: Salina Bell Gorman
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Gravitt Denton Co. Arkansas

14. Informant (Address): Lila Hollingshed Grangeville

15. Filed ~~August~~ 9-1-30 19..... B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930 to Aug 8, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 5:20 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental & Instantaneous
Crushed between Combine
and Goo tractor
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. D. Shumick, M. D.
....., 19..... (Address)

19. Place of Burial, Cremation, or Removal: Grangeville Ida
Date of Burial: 8-3-1930

20. Undertaker: Hanlock Mnd Co.
Address: Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71729

PLACE OF DEATH
County of Idaho
City of Grangeville

CERTIFICATE OF DEATH
Registration District No. 103
Primary Registration District No. 1001 Local Registrar's No. 22
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Libbie Perkins
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. D. Perkins

6. DATE OF BIRTH (month, day and year) 1843 May 5

7. AGE Years 87 Months 3 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lake County Indiana

PARENTS
10. NAME OF FATHER Lewis Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Mrs. S. J. Benedict Grangeville

15. Filed 9-1-, 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Aug 28, 1930
that I last saw her alive on Aug 27, 1930
and that death occurred, on the date stated above, at 3 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [illegible], M. D.
Aug 30, 1930 (Address) Grangeville Idaho

19. Place of Burial, Cremation, or Removal Grangeville Ida Date of Burial 8-31-1930

20. Undertaker Hancock Hnd. Co. Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71720

PLACE OF DEATH
County of Idaho
City of Cottonwood

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

10 B

2. FULL NAME Wilma Butler
(a) Residence. No. Cottonwood Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6. DATE OF BIRTH (month, day and year)

7. AGE Years ✓ Months ✓ Days ✓ If LESS than 1 day, 12 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Cottonwood Idaho
(State or country)

PARENTS

10. NAME OF FATHER Sam Butler
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Berdine Bies
13. BIRTHPLACE OF MOTHER (city or town) Salem S. Dak.
(State or Country)

14. Informant Sam Butler
(Address) Cottonwood Ida.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug, 19
that I last saw her alive on Aug 14, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Aspiration Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prolapsed umbilical cord penetrating cord
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) J D Shimuck M. D.
Aug 25, 1930 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cottonwood Idaho
Date of Burial Aug 15 1930

20. Undertaker Vassar's
Address Grangeville Ida.

ailor

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED SEP 11 1930

1. PLACE OF DEATH
County of Idaho
City of Fenan
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183

File No. 1
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sofia Von Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Widowed

6. DATE OF BIRTH: January (Month) 13 (Day) 1842 (Year)

7. AGE: 88 Yrs. 2 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vandoper, Germany

10. NAME OF FATHER: John Henry Rafe

11. BIRTHPLACE OF FATHER (State or Country): Vandover, Germany

12. MAIDEN NAME OF MOTHER: Charlatte Driver

13. BIRTHPLACE OF MOTHER (State or Country): Vandover, Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Mc Grane
(Address) Grangeville, Idaho

15. Filed Aug 26 1930 H. F. Orr D.B. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1929 to Aug 23 1930
that I last saw her alive on Aug 23 1930
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley Orr M. D.
8/25 1930 (Address) Cottonwood, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver, Idaho — DATE OF BURIAL: Aug 26 1930

20. UNDERTAKER: Vernon — ADDRESS: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 3—6M—1-30.

Original Record for State Registrar

RECEIVED SEP 15 1930

STATE OF MONTANA
Bureau of Vital Statistics
Standard Certificate of Death

Do not write in this space

1. PLACE OF DEATH

County Idaho Co Registered No. 191

Township LoLo National Forrest or Village ..... or

City Wind Lake, in Lolo National Forest No. ..... St., ... Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 days. How long in U. S. if of foreign birth? 45 yrs. ..... mos. ..... days

2. FULL NAME Max Gowin

(a) Residence: No. ..... St., ... Ward. Missoula Montana
(Usual place of abode) (If nonresident give city or town and State)

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: --------

6. DATE OF BIRTH (month, day, and year): 1865 ?

7. AGE: Years 65 ? Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper,** etc. cook

9. Industry or business in which work was done, as **silk mill, saw mill, bank,** etc. hotels and camps

10. Date deceased last worked at this occupation (month and year) Aug 7 30

11. Total time (years) spent in this occupation 45 yrs

12. BIRTHPLACE (city or town) (State or country) Germany

FATHER

13. NAME Mr Gowin

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Do not know

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT (Address) friends

18. BURIAL, CREMATION, OR REMOVAL
Place Missoula Date Aug 11 1930

19. UNDERTAKER (Address) John Forkenbrock Missoula Mont.

20. FILED Aug. 11, 1930 F. D. Pease Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Aug 7, 1930

22. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

I last saw h..... alive on ....., 19....., death is said to have occurred on the date stated above, at ..... m.

The **principal cause of death** and related causes of importance in order of onset were as follows:

	Date of onset
Cerebral Hemorrhage	Aug 7 1930
(Over See other side)	

Contributory causes of importance not related to principal cause:

Name of operation ....., Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (**violence**) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in **industry**, in **home**, or in **public place.**

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) John Forkenbrock Coroner D.

(Address) Missoula Mont.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 e
V. S. No. 98

RECEIVED SEP 15 1930

2

State of Montana

DEPARTMENT OF PUBLIC HEALTH

W. F. COGSWELL, SECRETARY

HELENA,

September 12, 1930

State Registrar of Vital Statistics,
Boise, Idaho.

Dear Sir:

Enclosed please find the death record of Max Gowin which was signed by the coroner of Missoula County and registered by our local registrar Doctor Pease of Missoula, Montana. The notation on the reverse side of the record, I believe, is self-explanatory and we are sending the record to you as the death occurred in your state.

Yours very truly,

L. L. Benepe,
Deputy State Registrar,
and
Special Agent, Census Bureau.

LLB/DB
Encl.

STATE OF IDAHO

RECEIVED SEP 13 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71733

PLACE OF DEATH

County of Jefferson

City of Rigby

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Anderson. #2

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 36 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Widowed.

5a. If married, widowed, or divorced
~~HUSBAND OF~~
(or) WIFE of Jens Anderson.

6. DATE OF BIRTH (month, day and year) June 3, 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	2	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Denmark.
(State or country)

PARENTS

10. NAME OF FATHER Niels Nielsen.

11. BIRTHPLACE OF FATHER (city or town) Denmark
(State or Country)

12. MAIDEN NAME OF MOTHER Annie Caroline

13. BIRTHPLACE OF MOTHER (city or town) Denmark.
(State or County)

14. Informant J. C. Anderson
(Address) Rigby, R. #2

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Sept 1, 1930, that I last saw her alive on Sept 1, 1930, and that death occurred, on the date stated above, at 1:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Cholelithiasis with Purulent Cholecystitis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) ....yrs. ....mos. 2 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory

(Signed) W. K. Abbott, M. D.

Sept 3, 1930 (Address) Rigby Ida

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: Sep. 4 30

20. Undertaker C. B. Eckersell. Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED SEP 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Jefferson
City of Rigby

Registration District No. 78
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Charles Gilbert Rolfe.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Ellen M. Rolfe.

6. DATE OF BIRTH (month, day and year) Sept. 29, 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Calif.

PARENTS

10. NAME OF FATHER Gilbert Hathway. Rolfe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) U.S.A.

12. MAIDEN NAME OF MOTHER Liza Jane Bates.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant David J. Rolfe
(Address) Rigby, R.J. #2

15. Filed 9/10, 1930. A B Eckersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st, 1930, to Sept 5, 1930
that I last saw him alive on Aug 25 1930
and that death occurred, on the date stated above, at 3 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility (Old age)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) A. C. Anderson M. D.
Sept 8, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 9/8/30 19

20. Undertaker A B Eckersell Address: Rigby

RECEIVED SEP 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71735

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.

PLACE OF DEATH
County of Jefferson
City of Ririe

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Bertha Mc Corkle

(a) Residence. No. Ririe Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Aug 9 - 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	7 hrs.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Ririe Idaho.

PARENTS

10. NAME OF FATHER Lafayette Mc Corkle.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Carrie Yost.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebraska.

14. Informant Mrs. Carrie Mc Corkle.
(Address) Ririe Idaho.

15. Filed 8/21, 1930. W Eckersell. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 10, 1930
that I last saw h[illegible] alive on Aug 10, 1930
and that death occurred, on the date stated above, at 2:00 a. m.
The CAUSE OF DEATH* was as follows:

Prematurity (5 mo. gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W. R. Abbott, M. D.
Aug 11, 1930 (Address) Ririe Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
None.	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED SEP 13 1930

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Jefferson
City of Menan.

Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Mary Malinda Gunderson.
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed.

5a. If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Edward Gunderson.

6. DATE OF BIRTH (month, day and year) Aug. 2, 1857

7. AGE Years 73 Months 0 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS
10. NAME OF FATHER Duncan S. Casper.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Matilda Allison.
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) E C Gunderson Lorenzo, Idaho. R. #1

15. Filed Aug 16 1930 A B Edwards Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 15, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Aug. 15, 1930
that I last saw her alive on Aug. 14, 1930
and that death occurred, on the date stated above, at 6.30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Liver & Stomach
(Carcinoma)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? yes
What test confirmed diagnosis? above
(Signed) W. P. West M. D.
8/15, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal Annis, Idaho. Date of Burial 8/17/30 19

20. Undertaker A B Edwards Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71737

PLACE OF DEATH
County of Jefferson
City of Lorenzo R.D. #1

Registration District No. 98
Primary Registration District No. 2176.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Benington Dee Pierce
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 21-1928.
7. AGE: Years 1, Months 10, Days 14. If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Lorenzo. R. #1

PARENTS
10. NAME OF FATHER Lee Pierce
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lorenzo R #1
12. MAIDEN NAME OF MOTHER Mary L. Mitchell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Menan

14. Informant Lee Pierce
(Address) Lorenzo Route #1

15. Filed 8/8, 1930 A B Edsersell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ on Aug 5, 1930, to ✓, 19
that ~~I last saw~~ he was dead on my arrival ~~alive on~~, 19
and that death occurred, on the date stated above, at 7:30 P m.
The CAUSE OF DEATH* was as follows:
Drowning
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. A. Anderson, M. D.
Aug 7, 1930 (Address) Ryby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cedar Butte Ida. Date of Burial: Aug. 8 1930
20. Undertaker: Vern J. Keller Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71738

PLACE OF DEATH
County of Jefferson
City of Roberts

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie Stibal 90
(a) Residence. No. 3 miles So of Roberts St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: William Stibal

6. DATE OF BIRTH (month, day and year): Aug 16-1878

7. AGE: Years 51, Months 9, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Czecho Slovaki

PARENTS
10. NAME OF FATHER: Joseph.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Czecho Slovakia
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Czecho Slovaki

14. Informant: William Stibal
(Address): Roberts Idaho

15. Filed JUN 1 1930, 19..
C. H. GAVIN, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1913, to 5/17, 1930
that I last saw her alive on 5/17, 1930
and that death occurred, on the date stated above, at 5 A. m.
The CAUSE OF DEATH* was as follows:
mitral stenosis
chronic myocarditis - chronic endocarditis -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Rheumatical arthritis - deformans over (duration) 17 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Earl D. Jones, M. D.
5/19, 1930 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: May 28 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 28 1930

PLACE OF DEATH

County of Jefferson

City of Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71730

Registration District No. 98

Primary Registration District No. 2176

Local Registrar's No. 14

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

99a

2. FULL NAME Myron Herbert Campbell.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Babe

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Babe

6. DATE OF BIRTH (month, day and year): Jan.15,1930

7. AGE: Years 0 | Months 2 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Babe

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Rigby, Idaho.

PARENTS

10. NAME OF FATHER: Herbert Earl Campbell.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Rigby, Idaho.

12. MAIDEN NAME OF MOTHER: Effie Lovina Bates

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Colo.

14. Informant: Herbert Campbell
(Address) Rigby, Idaho.

15. Filed JUN 1 1930, 19.... C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1930 (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1930, to Apr 9th, 1930

that I last saw him alive on Apr 9th, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary): Measles

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. A. Anderson, M. D.

Apr 10, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. | Date of Burial: 4/11/30 19

20. Undertaker: A B Eckersell | Address: Rigby

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7124

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 5176
(No.)
Local Registrar's No. 13

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Omer Samuel Call.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Anna Metta Call

6. DATE OF BIRTH (month, day and year) Sept 25 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	7	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Omer Call.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Sarah Ferrin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U.S.A.

14. Informant Mrs. O. S. Call.
(Address) Rigby Idaho.

15. Filed JUN 1 1930, 19 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to May 13, 1930
that I last saw him alive on May 12, 1930
and that death occurred, on the date stated above, at 7:25 P m.

The CAUSE OF DEATH* was as follows:
Apoplexy. Paralysis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) H. A. Anderson, M. D.
May 14, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Rigby, Idaho.	5/16/30

20. Undertaker Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7171

PLACE OF DEATH
County of Jefferson
City of Lewisville.
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 12
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Baby Taylor.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Babe

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Idaho.
(State or country)

PARENTS

10. NAME OF FATHER L. W. Taylor.

11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Lila Penrod.

13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or Country)

14. Informant L. W. Taylor
(Address) Lewisville, Idaho.

15. Filed JUN 1 1930 C. H. GAVIN, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~on~~ May 15, 1930, to ✓, 19✓
that I last saw him alive on May 16, 1930
and ~~that~~ death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows:
Probably Cardiac.
Was born with low
vitality lived one day only
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? NO Date of ✓
Was there an autopsy? NO
What test confirmed diagnosis? None.
(Signed) H. A. Anderson, M. D.
May 18, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Annis, Idaho.	5/17/30 19

20. Undertaker A B Eckersell
Address Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7179

PLACE OF DEATH
County of Jefferson
City of Lewisville.

Registration District No. 98
Primary Registration District No. 2176

Local Registrar's No. 11

(No. 1010)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Don Carlos Walker.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or ~~WIFE of~~) Lavina Lee Walker

6. DATE OF BIRTH (month, day and year) May 21, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	11	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) Utah
(State or country)

PARENTS

10. NAME OF FATHER Wm. H. Walker
11. BIRTHPLACE OF FATHER (city or town) Vermont
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Ann Shadon
13. BIRTHPLACE OF MOTHER (city or town) N. Y.
(State or Country)

14. Informant Mrs. Lavina Walker
(Address) Lewisville, Idaho.

15. Filed JUN 1 1930, 19.... C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 10th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6th, 1930, to Apr 10th, 1930
that I last saw him alive on Apr 10th, 1930
and that death occurred, on the date stated above, at 1:30 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. A. Anderson, M. D.
Apr 12th, 1930 (Address) Ray by Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville, Idaho.	4/14/30

20. Undertaker A. B. Eckersell Address Rigby

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11763

PLACE OF DEATH
County of Jefferson
City of Perry
Registration District No. 98
Primary Registration District No. 216
Local Registrar's No. 10
(No.) 493
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Annie Charlottie Nielsen.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F. M.	White	Married.

5a. If married, widowed, or divorced
(or) WIFE of Soren Peter Nielsen.

6. DATE OF BIRTH (month, day and year) March 4, 1872

7. AGE	Years	Months	Days	If LESS than 1 day,
	58	1	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Erastus Petersen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Whilhelmina Johnson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden.

14. Informant Soren Peter Nielsen
(Address) Rigby, R. #3

15. Filed JUN 1930, 19 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 20, 1930
that I last saw h er alive on April 20, 1930
and that death occurred, on the date stated above, at 8:05 P. m.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic nephritis and Uremia
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical and Laboratory
(Signed) W. R. Abbott, M. D.
Apr 21, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton, Idaho.	4/22/30 19

20. Undertaker [illegible] Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1164

PLACE OF DEATH

County of Jefferson
City of Lorenzo,
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 9
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Jane Browning.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 26th 1836

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
93	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinous

PARENTS

10. NAME OF FATHER Phillip Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Fred S Browning
(Address) Lorenzo Idaho.

15. Filed JUN 1 1930 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. (Month) 25, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19..., to —, 19...
that I last saw her alive on —, 19...
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

"Senility"

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. R. Yeat, M. D.
Mar 27, 1930. (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cedar Butte Cem.	Mar. 28 1930
20. Undertaker	Address
Owen J. Keller	Rigburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 71745

PLACE OF DEATH
County of Jefferson
City of Rigby Rt #1

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 8
(No. 16H)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adam Gneeting

(a) Residence. No. ..... St. Rigby R.F.D. #1
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 79 yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Caroline Gneeting

6. DATE OF BIRTH (month, day and year) May 3, 1842

7. AGE	Years	Months	Days	If LESS than 1 day,
	88	0	4	... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant William Gneeting
(Address) Rigby R. F. D. #1 Idaho

15. Filed JUN 1 1930 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1930, to ... 19..., that I last saw him alive on May 6 1930, and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH* was as follows:
Old age
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Address Idaho
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam

(Signed) H. A. Anderson, M. D.
May 9th 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan, Utah	May 9 1930
20. Undertaker Herbert A. Wood	Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED AUG 28 1930

CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 7176

County of Jefferson. Registration District No.
City of Rigby. Primary Registration District No. 2176
Local Registrar's No. 7

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

148c

2. FULL NAME Virginia Kelly

(a) Residence. No. Idaho Falls Ida.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Reid Kelly

6. DATE OF BIRTH (month, day and year): May 6 1906

7. AGE — Years: 23 | Months: 11 | Days: 7. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS

10. NAME OF FATHER: E. J Coughlan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scranton Penn
12. MAIDEN NAME OF MOTHER: Lulu May Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Topeka Kans

14. Informant: Mr E. J. Coughlan
(Address): Idaho Falls Idaho

15. Filed 4/16, 1930. [illegible] M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13. 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw her alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental
Automobile left Road
and turned over
Instant (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] Coroner, M. D.
4/16, 1930 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	April 17-30
20. Undertaker	Address
[illegible] H. McHan	Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7174

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No. 6

PLACE OF DEATH

County of Jefferson
City of Clark.
(No.) 14a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Candis Stine.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	11	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER Amon Harmon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Margaret Scott.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant A. A. Harmon
(Address) Rigby #2.

15. Filed JUN 1 1930 19 C. H. GAVIN, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930, to May 13, 1930
that I last saw her alive on May, 19
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) 3 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Kerr M. D.
5/24, 1930 (Address) Rigby, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville Ida.	May 11 1930
20. Undertaker	Address
Verne J. Keller.	Teton

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7175

PLACE OF DEATH

County of Jerome

City of Hazelton

Registration District No. 23

Primary Registration District No. 2017

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME John Talma Palmer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
14			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Kimberly Ida.

PARENTS

10. NAME OF FATHER Alfred Palmer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Olsalson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Alfred Palmer
(Address) Hazelton Ida.

15. Filed 9-9, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 7, 1930
that I last saw him alive on Aug 7, 1930
and that death occurred, on the date stated above, at 5:15 P m.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) S Hopper, M. D.

, 19 (Address) Hazelton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Placé of Burial, Cremation, or Removal	Date of Burial
Twin Falls	8-9 1930

20. Undertaker	Address
White Mortuary	Twin Falls.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7170

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 13
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. FULL NAME Robert D. Swanson

(a) Residence. No. 701 Garden Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 6, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	0 hrs. or 0 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Coeur D' Alene, Idaho.

PARENTS

10. NAME OF FATHER Roland Swanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.
12. MAIDEN NAME OF MOTHER Ardath Evens
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Roland Swanson
(Address) Coeur D' Alene, Idaho.

15. Filed 7-29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 6, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 6, 1930, to August 6, 1930
that I last saw him alive on August 6, 1930
and that death occurred, on the date stated above, at 9:45 P. m.
The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Harold T. Anderson, M. D.
August 7, 1930 (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	aug 7 1930
20. Undertaker	Address
Mooney Mortuary	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71750

PLACE OF DEATH
County of Kootenai
City of Camp 14 Winton Lumber Co

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 114

146

2. FULL NAME Gust Dahlquist
(a) Residence. No. Spokane Wn St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of 1881

6. DATE OF BIRTH (month, day and year)

7. AGE Years 49 Months – Days – If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Timber Worker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Winton Lumber Co

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Winton Lumber Co Office
(Address) Coeur d'Alene, Ida.

15. Filed 8/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10:05 A m.
The CAUSE OF DEATH* was as follows:
Skull Fractured, By flying Rock,
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) R. B. Mooney Coroner, M. D.
Aug 22, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial Aug 23 1930

20. Undertaker R. B. Mooney
Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71751

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 115

2. FULL NAME Ella Mann

(a) Residence. No. Post Falls St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

41

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 15 1857

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~[illegible]~~ Penn

PARENTS

10. NAME OF FATHER Lenord Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S.
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs F. R. McCormick
(Address) Post Falls, Idaho

15. Filed 8/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17, 1930, to Aug. 18, 1930
that I last saw her alive on Aug 18, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Septicemia following operation for Carcinoma of breast. (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of July 17-30
Was there an autopsy? no.
What test confirmed diagnosis? Symptoms.
(Signed) Chas. E. Butts, M. D.
Aug. 19, 1930 (Address) Spokane Wash.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery
Date of Burial: Aug 20, 1930

20. Undertaker: R B Mooney
Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71753

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 118

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Lawson L. McCurdy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Nettie McCurdy

6. DATE OF BIRTH (month, day and year) 1866-2-25

7. AGE Years 64 Months 5 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Medical Doctor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Madelia Minn

PARENTS
10. NAME OF FATHER J. B. K. McCurdy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Emma Driggers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Miss Nettie McCurdy
(Address) Coeur d'Alene Ida

15. Filed 8/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10, 1930, to Aug. 15, 1930
that I last saw him alive on Aug 15, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Pneumonia, lobar, left lower
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Jaundice, of unknown origin (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold T. Anderson, M. D.
Aug 17, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C. D'Alene — Date of Burial 8-18 1930

20. Undertaker Cassedy Funeral Home — Address C. D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7175

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 119

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Orville J. Feely

(a) Residence. No. Rathdrum Prairie
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1912 - 3 - 31

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	4	16	hrs. or min.

8. OCCUPATION OF DECEASED Laborer
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rathdrum Prairie
(State or country) Ida.

PARENTS

10. NAME OF FATHER J. J. Feely

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Elsie Hendricks

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) S. D.

14. Informant J. J. Feely
(Address) J. J. Feely

15. Filed 8/29, 1930 N. J. Sturgus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 17 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1930, to Aug. 17, 1930
that I last saw him alive on Aug. 16, 1930
and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:
Accidental gasoline burn over upper part of body.
on Aug. 15. 1930
(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John Ollard, M. D.
Aug. 18, 1930 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD'Alene	8-19 1930
20. Undertaker	Address
Ross-Cady Funeral Home	CD'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71755

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene - Dalton Gardens
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 120

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 a

2. FULL NAME August Harp.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sara P. Harp.

6. DATE OF BIRTH (month, day and year) 12 - 29

7. AGE Years 69 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER ------ Harp.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Julia Martell
(Address) Coeur d'Alene Idaho R 2

15. Filed 8/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930 to Aug 10, 1930
that I last saw him alive on Aug 10, 1930
and that death occurred, on the date stated above, at 10:15 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia - Lobar

..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Cardio - Renal

..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Harold J Sturges M. D.
Aug. 11, 1930 (Address) Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 8-13 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71756

PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene

Registration District No. 36
Primary Registration District No. 1050

Local Registrar's No. 121

(No.) 32
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Ellsworth Hedberg

(a) Residence. No. 200 - Indiana St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1926 - 9 - 11

7. AGE

Years	Months	Days	If LESS than 1 day,
3	10	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur d'Alene Ida
(State or country)

PARENTS

10. NAME OF FATHER Ellsworth Hedberg
11. BIRTHPLACE OF FATHER (city or town) Plum City, Wis.
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth Johnson
13. BIRTHPLACE OF MOTHER (city or town) Sweden.
(State or Country)

14. Informant Ellsworth Hedberg
(Address) Coeur d'Alene, Ida.

15. Filed 8/29, 1930 H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26, 1930, to Aug 10, 1930
that I last saw him alive on Aug 10, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
The appendectomy had no relation to his death - as reported by consultants.
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of July 30. - 30
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) E L Spohn, M. D.
Aug 11, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D'Alene
Date of Burial 8-11 1930

20. Undertaker Cassedy Funeral Home
Address C D'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71757

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 122

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

169

2. FULL NAME Edward Willis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word) Dont Know

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE about Years 72 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Chas McDonald Sheriff
(Address) Coeur d'Alene Ida

15. Filed 8/29, 1930 H. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

suicidal drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

~~What test confirmed diagnosis?~~ Justice of the Peace

(Signed) Eugene Best, ~~M. D.~~

July 23rd 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Evergreen Cem. Rathdrum — Date of Burial: 7-24 1930

20. Undertaker: Cassedy Funeral Home — Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71758

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 123

182

2. FULL NAME Martin Brandvold

(a) Residence. No. ..... St. Spokane. Wash.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Judith Brandvold

6. DATE OF BIRTH (month, day and year) 1869 - 2 - 28

7. AGE Years 61 Months 6 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Ole Brandvold
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Dont-Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Ingvold Brandvold
(Address) Coeur d'Alene. Ida

15. Filed 9/4, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 1. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Drowning - Accidental
About Sept 1. 1930
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Modification
(Signed) H. J. Sturges, M. D.
Sept 6. 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 9-6 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71759

PLACE OF DEATH
County of Kootenai
City of C. W. A.

Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 124
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Abbie J. Anthony
(a) Residence. No. Hayden Lake St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of E. A. Anthony
6. DATE OF BIRTH (month, day and year) 1846
7. AGE Years 84 Months 12 Days 2 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) S. Adams Massach.

PARENTS
10. NAME OF FATHER Charles Marsh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U.S.
12. MAIDEN NAME OF MOTHER — Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U.S.

14. Informant E. T. Anthony
(Address) Boise Idaho
15. Filed 9/4, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930, to Aug 30, 1930
that I last saw her alive on Aug 30, 1930
and that death occurred, on the date stated above, at 6:35 P.m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) Harold J Sturges M. D.
Sept 2, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial 9/2 1930
20. Undertaker R B Mooney
Address Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7176

Local Registrar's No. 125

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 30

Primary Registration District No. 1050

(No.) 74 B

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gertrude Elizabeth Mahaffey

(a) Residence. No. 724 - Bancroft St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of O. H. Mahaffey

6. DATE OF BIRTH (month, day and year) 1891 - July 8

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	1	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant O. H. Mahaffey

(Address) Coeur d'Alene Ida

15. Filed 9/4, 1930 N. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-30-, 1930, to 8-30-, 1930

that I last saw her alive on 8-30, 1930

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Embulus in brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Confinement

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Reed, M. D.

9-1-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. CDAlene	9-2 1930
20. Undertaker Cassedy Funeral Home	Address CDAlene

RECEIVED SEP 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

PLACE OF DEATH

County of Kootenai

City of Worley

CERTIFICATE OF DEATH

Registration District No. 126

Primary Registration District No.

(No.)

Local Registrar's No. 13.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Edith (Kennedy) Wright

146

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Francis Wright

6 DATE OF BIRTH (month, day and year) Dec. 20, 1891

7 AGE: Years 38 | Months 0 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mother and wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wheeling Missouri

PARENTS

10 NAME OF FATHER John Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisville Kentucky

12 MAIDEN NAME OF MOTHER Katherine Van Horne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Joliet Illinois

14 Informant Hyatha Wright

(Address) Worley Idaho

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July (Month) 13 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to July 13, 1930, that I last saw her alive on July 13, 1930, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Puerperal Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dead Fetus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R Clanton M. D.

July 13, 1930 (Address) Rockford, Wy

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Worley Ida. | Date of Burial: July 14 1930

20. Undertaker: [illegible] | Address: Plummer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71793

PLACE OF DEATH
County of Kootenai
City of Black Lake.

Registration District No. 126
Primary Registration District No. 2304
(No. Residence.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

88B

2. FULL NAME Andrew Benson
(a) Residence. No. Mullan Idaho St. Mullan, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years Months Days If LESS than 1 day, hrs. or min.
About 50
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Gold Hunter Mining Co.
9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Gust Pearson
(Address) Black Lake, Idaho
15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to July 28, 1930
that I last saw him alive on July 28, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Probably myocarditis
(duration) yrs. hours mos. ds.
CONTRIBUTORY (Secondary) Overeating high blood pressure (Heavy break fast - hard work in sun - Insulation?) (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) H. W. Shryock, M. D.
July 31, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mullan, Idaho
Date of Burial Aug. 2 1930
20. Undertaker J. A. Bever Ward and Co.
Address Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71763

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 10

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

207

2. FULL NAME Fred Edward Fuoco

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white (Italian)
5. Single, Married, Widowed, or Divorced (write the word) baby —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Nov. 24, 1928

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work baby —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg. Ida.

PARENTS

10. NAME OF FATHER Guy Fuoco.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy.
12. MAIDEN NAME OF MOTHER Julia Charmella Damiano
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Harrison Ida.

14. Informant Guy Fuoco (father)
(Address)

15. Filed July 10, 1930. H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 10, 1930
that I last saw him alive on July 9, 1930
and that death occurred, on the date stated above, at 3:30 A.m.
The CAUSE OF DEATH* was as follows:

Accidental scalding - hot coffee
Inspirated a little causing
Edema of Larynx (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
..... (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? —
(Signed) H W Shryock, M. D.
July 11, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison Ida
Date of Burial 7-11 1930

20. Undertaker Cassedy Funeral Hq
Address Harrison

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71764

PLACE OF DEATH

County of Kootenai
City of Harrison
600 ft North of City limits

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 9

189 e

2. FULL NAME Dudley Carson Boyles Hot Lake Oregon
(a) Residence. No. Hot Lake Sanatorium St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Goldie Boyles

6. DATE OF BIRTH (month, day and year): 3-29-1876

7. AGE: Years 54 | Months 3 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Chief Clerk of Hot Lake Sanatorium
(b) General nature of industry, business, or establishment in which employed (or employer): Medical & Surgical Sanatorium
(c) Name of employer: Dr W.T. Phy

9. BIRTHPLACE (city or town) (State or country): St Joseph Mo.

PARENTS

10. NAME OF FATHER: Jasper Boyles.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): St Joseph Mo
12. MAIDEN NAME OF MOTHER: Matilda Marlen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ———

14. Informant: Geo Hull
(Address): Constable Harrison Ida

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8, 1930, to July 8, 1930 that I last saw him alive on July 8, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental - Auto - rolled over embankment.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Fractures multiple shock — lived 1½ hrs. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ———
Did an operation precede death? ——— Date of .....
Was there an autopsy? no
What test confirmed diagnosis? ———

(Signed) H.W. Shryock, M. D.
July 8, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cleveland, Alene Ida — Date of Burial: 7-9 1930

20. Undertaker: Cassady Funeral Home — Address: C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71765

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Josephine Fonti

(a) Residence. No. Harrison Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Woman	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dominico Fonti

6. DATE OF BIRTH (month, day and year) March 19-1842

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Dont Know.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Mrs Lucia De Andrea
(Address) Harrison Idaho

15. Filed July 30-1930, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3, 1930, to July 3, 1930
that I last saw her alive on July 3, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:

Senility
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) N. W. Shryock, M. D.
July 1, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Ida.	8-1 1930
20. Undertaker	Address
Cursed Funeral Home	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71766

PLACE OF DEATH
County of Latah
City of Troy
Registration District No. 64
Primary Registration District No. 2144
(No. Troy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

164

2. FULL NAME Elvina Collins

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2 - 1846

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Not Kown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Not Kown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John Collins
(Address) Deary Ida

15. Filed Aug 14, 1930 Lucy M Pickard Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1930, to Aug. 11, 1930, that I last saw h~~er~~ alive on Aug 11, 1930 and that death occurred, on the date stated above, at 1045 m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) C. O. Meyer, M. D.
Aug. 11, 1930 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moon Idaho	Aug 14 1930
20. Undertaker	Address
John J. Pickard	Troy Ida

RECEIVED AUG 18 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Latah

Primary Registration District No. 1011

File No. 7126

City of Moscow (No. ....., ... St.)

Registered No. 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joanne Kidwell

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Child

6. DATE OF BIRTH: May 21 (Month) (Day) 1930 (Year)

7. AGE: ..... yrs. 2 mos. 4 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spokane, Wash.

10. NAME OF FATHER: Wilbur R. Kidwell

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Christel Stinemates

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W.R. Kidwell
(Address): Moscow Idaho

15. Filed 8/12 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 25, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930 191 , to July 25 1930 that I last saw her alive on July 24 1930, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Whooping cough

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Stinemates M. D.

7/26 1930 (Address) Moscow Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 7/6/30 191

20. UNDERTAKER: H.R. Short — ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19780

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71769

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 30

1889

2. FULL NAME Andre CLARENCE BERGSENG

(a) Residence. No. St. Roundup Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 16, 1899

7. AGE: Years 30, Months 8, Days, If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter (Bridge)
(b) General nature of industry, business, or establishment in which employed (or employer): U.P. Railroad
(c) Name of employer: U.P. Railroad

9. BIRTHPLACE (city or town) (State or country): Minneapolis Minn.

PARENTS

10. NAME OF FATHER: Anton Bergseng
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Lizzie Bergseng
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Lizzie, Bergsen
(Address) Roundup, Mont.

15. Filed 7/12, 1930. J. Harry Einhorn, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 16th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16, 1930, to July 16, 1930
that I last saw him alive on July 16, 1930
and that death occurred, on the date stated above, at 12:30 P m.
The CAUSE OF DEATH* was as follows:
Accidental-
Skull crushed by heavy timbers
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
7/17/30, 19 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Roundup, Mont — Date of Burial: 7/20/30

20. Undertaker: R. M. Grim — Address: Moscow, Ida

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 29

(No. Gritman hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

148

2. FULL NAME Lucille Carol McAuley Gustaveson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Gustaveson

6. DATE OF BIRTH (month, day and year) August 26, 1896

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
33	10	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Americus
(State or country) Kansas

PARENTS

10. NAME OF FATHER Winfield Scott McAuley

11. BIRTHPLACE OF FATHER (city or town) Not known
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Jane Edmiston

13. BIRTHPLACE OF MOTHER (city or town) Not known
(State or Country)

14. Informant Peter Gustaveson
(Address) Moscow, Idaho

15. Filed 8/12, 1930 Thos. Entwistle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 10, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to July 10, 1930
that I last saw her alive on July 10, 1930
and that death occurred, on the date stated above, at 9:40 A m.

The CAUSE OF DEATH* was as follows:

Puerperal eclampsia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. L. Gritman, M. D.
7/12, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	7/13/30 19
20. Undertaker R. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7177

Local Registrar's No. 28

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emil Johnson

(a) Residence. No. 624 Harrison St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Justina Johnson

6. DATE OF BIRTH (month, day and year) Dec. 25, 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	6	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Charles Johnson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Justina Johnson

(Address) Moscow, Idaho

15. Filed 8/12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1930, to June 30, 1930

that I last saw him alive on June 30, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. ds.

I do not know
CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. L. Gritman, M. D.

7/5/30, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	7/6/30

20. Undertaker H.R. Short

Address Moscow

Short

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-19 RECEIVED SEP 12 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 63

County of Latah

Primary Registration District No.

File No. 1

City of Near Kendrick (No. ....., ... St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marit Voguild

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

July 7 (Month) 1841 (Day) (Year)

7. AGE

89 yrs. ..... mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At home

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Cle Voguild

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T.A. Nelson

(Address) Kendrick, Ida.

15.

Filed 8/3 1930 B. F. Nesbit
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 164

July 31, 1930 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... to ..... 191 , that I last saw him alive on July 31 1930 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Degenerative disease.

Natural Causes.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) a few hours yrs. ..... mos. ..... ds.

(Signed) C.H. Magee M. D.

8/2 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Big Bear Ridge	8/3/30 191

20. UNDERTAKER	ADDRESS
[illegible]	Moscow

SVMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7178

PLACE OF DEATH

County of Latah
City of
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. 63)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16

2. FULL NAME Mrs. Elizabeth Jane Wells

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 39 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Aaron J. Wells

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	4	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Penn

PARENTS

10. NAME OF FATHER: Geo. Mowry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: ~~—~~ Hales
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Mrs. Frank Sanders
(Address): Southwick Ida.

15. Filed Aug 9, 1930 D. F. Nesbit, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug. 8, 1930, that I last saw her alive on Aug. 3, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:
Carcinamatosis peritonei
(duration) 1 or more yrs. mos. ds.
CONTRIBUTORY (Secondary): Nil
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical course
(Signed) C. H. Fiebel, M. D.
Aug. 8, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Southwick	Aug. 10 1930
20. Undertaker: None	Address

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11[illegible]

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jacob Johnson

90

(a) Residence. No. (Usual place of abode) Salmon Idaho St.
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 45			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Wm C Jacobs
(Address) Salmon Idaho

15. Filed 9/10, 19[illegible] [illegible] Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 10, 1930, to Aug 19, 1930
that I last saw him alive on Aug 18, 1930
and that death occurred, on the date stated above, at 1 8 — m.
The CAUSE OF DEATH* was as follows:
Organic heart disease
(aortic regurgitation)
approximate (duration) two yrs. years mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hamner, M. D.
Sept 11, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	8-20th 1930
20. Undertaker	Address
Wm C Jacobs	Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Lemhi
City of Tendoy

Registration District No. 41
Primary Registration District No. 2116
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88B

2. FULL NAME Charles Gage
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Caucasian
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Jane Gage

6. DATE OF BIRTH (month, day and year)

7. AGE 62 Years | Months 2 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Edward Gage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Martha McFarland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Gertie Trowbridge
(Address) Tendoy Idaho

15. Filed 9/10, 1930 Cho Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 19" 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1929, to Aug 19" 1930
that I last saw him alive on Nov. 3" 1929
and that death occurred, on the date stated above, at 4.30 p.m.
The CAUSE OF DEATH* was as follows
Myocarditis & Agina Pectoris
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Webster, Iowa
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical signs
(Signed) Stratton M. D.
8/20, 1930. (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salmon Cemetery | Date of Burial 8/21st 1930

20. Undertaker Jim C Doebler | Address Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11775

PLACE OF DEATH

County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
(No.) 14
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Morris Hall Cottom

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Elizabeth B. Cottom

6. DATE OF BIRTH (month, day and year) July 21st 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	10	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER George W. Cottom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Elizabeth S. Rees
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant Philip Cottom
(Address) Leadore Ida

15. Filed 9/10, 1930 Chas Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to June 19, 1930
that I last saw him alive on June 19, 1930
and that death occurred, on the date stated above, at 7-30 P m.
The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Near Leadore
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
July 1, 1930 (Address) Salmon

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	6/22/1930

20. Undertaker W M C Hobbs — Address Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7177

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 30
Primary Registration District No. 2129.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15

49

2. FULL NAME Charles J. Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1864 - Sept. 10th

7. AGE

Years	Months	Days	If LESS than 1 day,
65	10	28	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant A. Kaline
(Address) Winchester, Idaho

15. Filed 8/4, 1930 R. Dwyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1930 to Aug. 8, 1930
that I last saw him alive on Dead when 1st seen
and that death occurred, on the date stated above, at 11:45A m.
The CAUSE OF DEATH* was as follows:
acute attack of angina pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Over work
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? History only.
(Signed) A.B. Halliday, M. D.
Aug 8, 1930 (Address) Winchester, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Golden Ridge Cemetary
Date of Burial: Aug. 10 1930

20. Undertaker: Brower & Wann
Address: Lewiston

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED SEP 10 1930

CERTIFICATE OF DEATH

71768

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah Registration District No. 60
Primary Registration District No. 21 M
City of Cottonwood File No.
If death occurs away from usual residence, give facts called for under special information. (No. Winchester St.) Registered No. 14
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin A. Lancaster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 14 (Day) 1857 (Year)

AGE: 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

OCCUPATION
Trade, profession or ticular kind of work: Stock Man
General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Isaac Lancaster
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Lancaster
(Address) Rice Creek

15. Filed 9/2 1930 C. P. Dunbar Local Registrar.

MEDICAL CERTIFICATE OF DEATH

74A

16. DATE OF DEATH July (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1930 to July 30 1930
that I last saw him alive on July 30 1930
and that death occurred on the date stated above, at 10.45 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 3 ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) 10 Yrs. ..... mos. ..... ds.
(Signed) John F. Gist M. D.
7/30 1930 (Address) Winchester Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos 2 days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? Cottonwood Idaho
Former or usual residence Cottonwood Idaho

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho — DATE OF BURIAL: Aug 1 1930
20. UNDERTAKER: Brown-Wynne Co — ADDRESS: Lewiston Ida

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71779

PLACE OF DEATH

County of Lewis
City of Craigmont

Registration District No. 60
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

49

2. FULL NAME × Clark Long.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6. DATE OF BIRTH (month, day and year) ×

7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Jeweler
(c) Name of employer

9. BIRTHPLACE (city or town) × St Jacobs, Ill
(State or country)

PARENTS
10. NAME OF FATHER ×
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) ×
12. MAIDEN NAME OF MOTHER ×
13. BIRTHPLACE OF MOTHER (city or town) ×
(State or Country)

14. Sign Informant ×
(Address)

15. Filed 7/6, 1930 R. E. Dunn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930 to July 18, 1930
that I last saw him alive on July 17, 1930
and that death occurred, on the date stated above, at 12 10 A m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. — mos. 11 ds.
CONTRIBUTORY (Secondary) Myocarditis
..... (duration) Sed yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) R. E. Dunn, M. D.
7/6, 1930 (Address) Craigmont

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: [illegible] Craigmont
Date of Burial: 7-20 1930

20. Undertaker: [illegible]
Address: Craigmont

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71789

PLACE OF DEATH
County of Lincoln
City of Shoshone

Registration District No. 16
Primary Registration District No. 1016
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

90

2. FULL NAME Emma Pease

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno David Pease

6. DATE OF BIRTH (month, day and year): Sept 9 - 1849

7. AGE: Years 80 | Months 11 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ~~Logansport~~
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Logansport Ind.

PARENTS

10. NAME OF FATHER: Henry Fidler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Catherine Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn

14. Informant: Grayce Peas
(Address)

15. Filed Sept 6, 1930 J L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1930, to Sept. 7, 1930
that I last saw her alive on Sept. 7, 1930
and that death occurred, on the date stated above, at 7 45 a. m.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis.
(duration) 10 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? no Date of —
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) [signature], M. D.
9-8, 1930 (Address) Shoshone Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Anthony Ida | Date of Burial: 9-9 1930

20. Undertaker: C E Hickok | Address: Shoshone Ida.

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 16

County of

RECEIVED SEP 16 1930

Primary Registration District No. 1616

City of

(No. St.)

State File No.

Local Registrar's No. 17

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Sept 6 (Month) [redacted] 1930 (Year)

7. AGE: Yrs. Mos. ds. If LESS than 1 day how many / hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Shoshone Ida

10. NAME OF Father: Jas. R Craig

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER: Ward Bancroft

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Ray Craig
(Address) Twin Falls

15. Filed Sept 6 1930 J L Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 6 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1930 to Sept 6 1930 that I last saw him alive on Sept 6 1930 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

a. Premature (6½ mos)

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) 6 yrs. mos. ds.

(Signed) T. E. Barnett M. D.

9/6 1930 (Address) Shoshone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL 19

20. UNDERTAKER: James Ray Craig — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71799

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 42

92

2. FULL NAME Florence Lucile Bagley.
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): married.
5a. If married, widowed, or divorced ~~HUSBAND or~~ (or) WIFE of: Fred Bagley.
6. DATE OF BIRTH (month, day and year)
7. AGE: 35 Years, Months 11, Days 14. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Logan Ut.

PARENTS
10. NAME OF FATHER: C. O. Peterson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Ellen Nelson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N Known

14. Informant: Fred Bagley
(Address): Rexburg #2.
15. Filed 9/4, 1930 J Rysburg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 3rd. (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1930, to Sept. 3, 1930
that I last saw her alive on Sept. 3, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Pulmonary Embolism
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Operation for Appendicitis
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Aug 29, 1930
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. B. Rigby, M. D.
Sept 4, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City. Date of Burial: Sept 6 1930
20. Undertaker: Vern J Keller Address: Rexburg

[illegible] information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71793

PLACE OF DEATH

County of Madison

City of Burton

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 41

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Wood

(a) Residence. No. ..... St. 162
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug, 28th 1930

7. AGE Years | Months | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burton-Idaho

PARENTS

10. NAME OF FATHER Joseph Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Welsville Utah

12. MAIDEN NAME OF MOTHER Ida Myers

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Joseph Wood

(Address) Rexburg R. D. 2

15. Filed 9/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Sept 2, 1930

that I last saw him alive on Sept 2, 1930

and that death occurred, on the date stated above, at 9 am m.

The CAUSE OF DEATH* was as follows:

inanition

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Lorin L. Rich M. D.

9-3, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burton Ida. | Date of Burial: Sept 2 1930.

20. Undertaker: Wm. J. Keller | Address: Rexburg

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71[illegible]

PLACE OF DEATH

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 40

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME James Laird Winmill

(a) Residence. No. 5 So - 3rd East St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rose Kaiser Ernsting

6. DATE OF BIRTH (month, day and year): Dec 25 - 1877

7. AGE: 53 Years, 8 Months, 6 Days. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Sheepman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Parley Canyon, Utah

PARENTS

10. NAME OF FATHER: Richard Winmill

11. BIRTHPLACE OF FATHER (city or town) (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Laird

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Irvin Parish Scotland

14. Informant: Mrs James L. Winmill

(Address): Rexburg Ida.

15. Filed 9/3, 1930 J Kyoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Aug 31, 1930

that I last saw him alive on Aug 31, 1930

and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows: Coronary Embolism

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Ulcerative Endocarditis

(duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death? place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Laboratory findings

(Signed) Lorin L Rich, M. D.

Sept 3 - 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sugar City. Date of Burial: Sept. 4 1930

20. Undertaker: Vern J Keller Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Madison
City of Lyman.

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 39

129

2. FULL NAME Emma Leonia Rytting

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married.

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Chas. F Rytting.

6. DATE OF BIRTH (month, day and year) Feb. 26. 1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	60			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grantsville Utah

PARENTS

10. NAME OF FATHER Andrew V. Millward

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Lucie Eastman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Chas F. Rytting
(Address) Lyman Ida.

15. Filed Aug 31, 1930 J Rytting Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930, to aug. 28, 1930
that I last saw her alive on Aug. 22, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis with arteriosclerosis. Organic Heart Disease.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Farley Nelson, M. D.
aug 31, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lyman Ida.	Sept. 1st 1930.
20. Undertaker	Address
Vern J Keller.	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71786

PLACE OF DEATH

County of Madison

City of Teton

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 38

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

204

2. FULL NAME Baby Bright

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 25, 1930

7. AGE Years Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Teton
(State or country) Idaho

PARENTS

10. NAME OF FATHER Artell Bright

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Teton Idaho

12. MAIDEN NAME OF MOTHER Edna Hollist

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Charles Bright
(Address) Teton

15. Filed 8/26, 1930 J Ryonwg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on Aug. 25, 1930

and that death occurred, on the date stated above, at 11:A m.

The CAUSE OF DEATH* was as follows:

Asphexia
Cord in double half hitch about the neck

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.

Aug 26, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Teton

Date of Burial 8/26/30 19

20. Undertaker Russel P. Flamm

Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Minidoka
City of Paul

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Michaels
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 3 1930
7. AGE Years Months Days If LESS than 1 day, 3 hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Paul Ida.

PARENTS
10. NAME OF FATHER Frank Michaels
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Stella Bunnell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City Ut.

14. Informant (Address) Frank Michaels Paul
15. Filed 8-11, 1930 E H Elmore Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 3, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Aug 3, 1930
that I last saw her alive on Aug 3, 1930
and that death occurred, on the date stated above, at 10 40 m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Gestation - About 7½ mo.
Failure of Foramen Ovale
to close, O (Blue Boby
..... (duration) ..... yrs. ✓ mos. 1 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19..... (Address) Rupert, Idaho

19. Place of Burial, Cremation, or Removal Paul Ida. Date of Burial Aug. 4 1930
20. Undertaker D. E. Johnson Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 21789

County of NezPerce
City of Lewiston
Registration District No. 46
Primary Registration District No. 1004
Local Registrar's No.
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Lester "ay Marvin

(a) Residence. No. Route #1 East Lewiston St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annna Marvin

6. DATE OF BIRTH (month, day and year) July 10 1877

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	10	27	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Night Watchman

(c) Name of employer Clearwater Timber Co.

9. BIRTHPLACE (city or town) Ill.
(State or country)

PARENTS

10. NAME OF FATHER Dont know

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) dont know

12. MAIDEN NAME OF MOTHER dont know

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) dont know

14. Informant
(Address)

15. Filed 7-1, 1930 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to June 6, 1930, that I last saw h[illegible] alive on June 6, 1930, and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary — T.B.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY —
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of findings

Was there an autopsy? no. Physical & X Ray

What test confirmed diagnosis?

(Signed) William [illegible], M. D.

June 6, 1930. (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	19
20. Undertaker	**Address**
Vassar Mortuary Inc	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7179

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Bert F. Savage

(a) Residence. No. Lewis & Clark Hotel St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edna Savage

6. DATE OF BIRTH (month, day and year) 12/13/1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	5	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Newspaper Man
(b) General nature of industry, business, or establishment in which employed (or employer) Telegraph Operator
(c) Name of employer Lewiston Tribune

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER John Savage
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Edna Savage
(Address) Lewiston Idaho

15. Filed 7-[illegible] 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1930, to June 2, 1930
that I last saw him alive on June 2, 1930
and that death occurred, on the date stated above, at 2-15 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Flu.
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
6-2, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	6/4 1930
20. Undertaker	Address
Wasson Mortuary	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71791

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. ~~Home~~ Lewiston Orchards St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Chas. F. Manning
(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Evangline Manning
6. DATE OF BIRTH (month, day and year)
7. AGE Years 64 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Old Town Maine
PARENTS
10. NAME OF FATHER M. Manning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "
14. Informant Evangline Manning
(Address) Lewiston Idaho
15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 23, 1930, to May 30, 1930
that I last saw him alive on May 30, 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Terminal Broncho-pneumonia (duration) yrs. mos. 5 ds.
18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) Paul G. Harvey, M. D.
June 12 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho Date of Burial 6/2 1930
20. Undertaker Vassar Mortuary Inc Address Lewiston

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7179

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1209
(No. White Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Mrs P. H. Williams

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of P. H. Williams

6. DATE OF BIRTH (month, day and year) May 29 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Needy Oregon

PARENTS
10. NAME OF FATHER Wm Moreland.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Jane Noblett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon.

14. Informant P. H. Williams
(Address) Lewiston Idaho

15. Filed 6-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1925, to May 19, 1930
that I last saw h[illegible] alive on May 19, 1930
and that death occurred, on the date stated above, at 10:20 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolus. 6 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteria-sclerosis-hypertension & Chr. interstitial nephritis
(duration) 7 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Cardinal Symptoms.
(Signed) E. L. White, M. D.
6-2, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	6/7 1930

20. Undertaker Vassar Mortuary Inc Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71793

PLACE OF DEATH
County of Nez Perce
City of Lewiston Route 2

Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hiram Jasper Earl
(a) Residence. No. Captain John Creek
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

11B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Raglan
6. DATE OF BIRTH (month, day and year) Aug 6 1856
7. AGE Years 73 Months 8 Days 26 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) "
(c) Name of employer "
9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER Perry G Earl
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.
12. MAIDEN NAME OF MOTHER Lucinda Bond
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant J. W. Earl
(Address) Lewiston Ida. Route 2
15. Filed Jan 1, 1930. Susan [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 5 (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/21, 1930, to 5/1, 1930
that I last saw h alive on 5/1/30, 19
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. H. McElrain M. D.
May 2, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Capt. John Creek
Date of Burial 4 of May 19
20. Undertaker Family Burial
Address [illegible]

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 220 - Fifth Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mary Welscher Krier

(a) Residence. No. 220 5th St St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 6 - 1858

7. AGE Years 71 Months 7 Days 28 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS
10. NAME OF FATHER Nicholas Welscher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Luxenburg
12. MAIDEN NAME OF MOTHER Catherine Schlim
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Luxenburg

14. Informant Mrs Sam Tannahill
(Address) Lewiston Idaho

15. Filed 5-1-, 1938 J. M. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 4, 1930
that I last saw her alive on April 4, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
apoplexy -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W O Clark M. D.
Apr 8, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 19

20. Undertaker Vassar Mortuary
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71795

PLACE OF DEATH

County of Nezperce

City of Lewiston Idaho

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Edna Louise Miles

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27, 1894

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35	8	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Office Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Camas Prairie R.R.Co.

9. BIRTHPLACE (city or town) (State or country): Cleveland, Va.

PARENTS

10. NAME OF FATHER: E.J. Miles

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cumberland, Md.

12. MAIDEN NAME OF MOTHER: Anna L. Clapp

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Le Banon

14. Informant: R.L. Miles (Brother)
(Address) Clarkston, Wash.

15. Filed 4-1, 1930 J.E. Bruce Registrar
Per JMR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 27th, 1930, to Mar 30th, 1930
that I last saw her alive on Mar 30th, 1930
and that death occurred, on the date stated above, at 8 30 a.m.
The CAUSE OF DEATH* was as follows:

Basal Fracture Skull
(duration) yrs. mos. 1 hr hrs ds.

CONTRIBUTORY (Secondary): Temporary Insanity
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Mar 27th 30
Was there an autopsy? No
What test confirmed diagnosis? Laboratory findings
(Signed) C. C. Carasow, M. D.
4/1, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Ida.
Date of Burial: 4/1/30 19

20. Undertaker: H.R. Merchant
Address: Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71796

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

114

2. FULL NAME Emory Herriman
(a) Residence. No. St. Orofino Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year): Dec 6 - 1925

7. AGE: Years 4, Months 8, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10. NAME OF FATHER: John Herriman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Phosa Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Michigan

14. Informant: John Herriman
(Address): Orofino Idaho

15. Filed 9-1, 1930 J. M. Cyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Aug 27, 1930
that I last saw him alive on Aug 26, 1930
and that death occurred, on the date stated above, at 12:30 p.m.
The CAUSE OF DEATH* was as follows:
Acute Enteritis.
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) - Eating Mirror front
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? Orofino - Ida
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs
(Signed) Welfare [illegible], M. D.
Aug 28, 1930 (Address) Lewiston - Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Idaho
Date of Burial: 19

20. Undertaker: Dassar Mortuary Inc
Address: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7178

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No. 1510)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Berthena Miles Hewett.

(a) Residence. No. Boston Avenue St. Clarkston Washn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Clyde Hewett.

6. DATE OF BIRTH (month, day and year) May 11-1908=

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	3	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — At Home —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oakesdale Washn

PARENTS

10. NAME OF FATHER E J Miles.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chamberlin Mo.
12. MAIDEN NAME OF MOTHER Anne L. Clapp.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lebanon Ky.

14. Informant R L Miles
(Address) 843 - 2nd Street Clarkston Wn

15. Filed 9-1, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1930, to Aug 27, 1930, that I last saw h[illegible] alive on Aug 27, 1930, and that death occurred, on the date stated above, at 4-30 P m.

The CAUSE OF DEATH* was as follows:
General Peritonitis
(General)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pyosalpinx + Chr appendicitis
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 13-30
Was there an autopsy? Yes
What test confirmed diagnosis? Cardinal symptoms

(Signed) E. R. White, M. D.
8-28, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	8/29 1930
20. Undertaker	Address
A R Merchant	Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Harry

DO NOT WRITE IN THIS SPACE

State File No. 71799

PLACE OF DEATH

County of Lewiston

City of Nez Perce

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Thos. DeShazer

(a) Residence. No. St. 100a
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 6, Months 1, Days 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colton Wn

PARENTS

10. NAME OF FATHER Chas. H. DeShazer

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Mable Morlin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant L B Warren

(Address) Lewiston Idaho

15. Filed 8-30, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Aug 23, 1930 that I last saw him alive on Aug 23, 1930 and that death occurred, on the date stated above, at 5:30 p m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Image

(Signed) B. G. Henry, M. D.

8/30, 1930 (Address) Lewiston Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial 8/25 1930

20. Undertaker: Brower-Ham Co — Address Lewiston

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7179

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1889
(If death occurred in a hospital or institution, give its name instead of street and number.) (No. St Joseph Hospital)
Local Registrar's No.

1000

2. FULL NAME Jerry Moriarty
(a) Residence. No. Snake River Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year): Feb 12 1874
7. AGE: Years 56 | Months 6 | Days 9 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Himself
9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10. NAME OF FATHER: Johny Moriarty
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14. Informant: Francis Moriarty
(Address): Winchester Idaho
15. Filed 9-1, 1930 J. H. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 22, 1930
that I last saw him alive on Aug 22, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Chr. Nephritis - Arterio Sclerosis
(duration) ? yrs. 2 mos. ? ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Phy. Exam
(Signed) Ralph M. Alley, M. D.
Aug 26, 1930 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho — Date of Burial: 8/26 1930
20. Undertaker: Cassar Moriarty — Address: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. The White Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 7180

Local Registrar's No.

126

2. FULL NAME Alma Levina Glasson.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of H. A. Glasson.

6. DATE OF BIRTH (month, day and year) Dec. 20th, 1892.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37.	7.	27.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kinzue.
(State or country) Pa.

PARENTS

10. NAME OF FATHER Charles W. Jay.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Pa.

12. MAIDEN NAME OF MOTHER Dolly Nancy Eddy.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant W. A. Glasson
(Address) Lewiston, Idaho.

15. Filed 9-1, 1930 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 17th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 17, 1930
that I last saw h[illegible] alive on Aug 17, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Gangrenous ruptured Appendicitis

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 14-30
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
8/18/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	8/20/30. 19
20. Undertaker	**Address**
Brower-Vann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71802

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 6
Primary Registration District No. 1609
(No. St. Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Mrs Johana Ruff.
(a) Residence. No. Hampster Idaho St. 131
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Was Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of August Ruff.

6. DATE OF BIRTH (month, day and year) Aug. 19 1872

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Emiliegin Ruff
(Address) Hampster Idaho

15. Filed 9-1, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Aug (Day) 14 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 14th, 1930, to Aug 14th, 1930, that I last saw h[illegible] alive on Aug 14th, 1930, and that death occurred, on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Uremia Coma
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis
(duration) + yrs. mos. ds.

18. Where was disease contracted if not at place of death? Hampster Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary & physical
(Signed) C C Cassaw, M. D.
Aug 14th, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Idaho — Date of Burial 8/14 1930
20. Undertaker Custer Mortuary Inc — Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71803

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

101a

2. FULL NAME Bernice Emma Bartrow

(a) Residence. No. 314 15th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 1 | Months 4 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer): Denver
(c) Name of employer: Colorado

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER: E. W. Bartrow
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Freda Mankin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Arkansas

14. Informant: E. W. Bartrow
(Address): Cety

15. Filed 8-30, 1930 M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-7-30, 19.... to 8-7-30, 19....
that I last saw her alive on 8-7-30, 19....
and that death occurred, on the date stated above, at 8 10 p. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia.

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Sign & symptoms
(Signed) H. Rouse, M.D.
8/30-30, 19.... (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: 8/8/30 19

20. Undertaker: Brower-Ham Co | Address: Lewiston Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71801

County of Nezperce
City of Lewiston, Ida.

Registration District No. 96
Primary Registration District No. 1009
(No. [illegible])
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Henry L Mizer

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary S Jameson

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 82, Months 11, Days 17. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Bradney Co. Tenn.

PARENTS

10. NAME OF FATHER: Elizah Mizer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Elizabeth Hale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Mrs Cora Sanford (Daughter)
(Address) Cloverland, Wash

15. Filed 8-29, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930 to July 31, 1930
that I last saw him alive on July 31, 1930
and that death occurred, on the date stated above, at 4 20/p m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Hemorrhoids —
Hydrocele (duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) D W. Palmer, M. D.
Aug 4, 1930 (Address) Clarkston Wn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston, Wash — Date of Burial: 8/3/30 19

20. Undertaker: H R Merchant — Address: Clarkston Wn.

Lyle.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71805

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

161a

2. FULL NAME Andrew Charles Harvill
(a) Residence. No. #9 — Kimball Const St
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 2nd 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER Charles D Harvill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Richland Oregon
12. MAIDEN NAME OF MOTHER Dovey Birch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant C. D. Harvill,
(Address) Lewiston, Idaho.

15. Filed Jan 1, 1930. Susan E Brace Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 13th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930 to Feb 13, 1930
that I last saw h[illegible] alive on Feb 13, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J M. Lyle. M. D.
2/15 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/15 1930

20. Undertaker	Address
Bower-Wann Co	Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Lyle

DO NOT WRITE IN THIS SPACE
State File No. 71806

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1019
(No. 1210 – 20th St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101B

2. FULL NAME George F Patter
(a) Residence. No. 1210 – 20th St St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 11/8/1847
7. AGE: 82 Years, Months 1, Days 28; If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Orland Canada

PARENTS
10. NAME OF FATHER: Patter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: A L Patter
(Address) Lewiston Idaho
15. Filed 2-1, 1930 S. E. Bruce Per J M L Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930 to Jan 3, 1930
that I last saw him alive on Jan. 3, 1930
and that death occurred, on the date stated above, at 7:30 a m.
The CAUSE OF DEATH* was as follows:
Static Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J M. Lyle, M. D.
1/6, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho
Date of Burial: 19
20. Undertaker: Brower-Wann Co Lewiston Idaho
Address

Lyle

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71807

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Benard McCabe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 18th 1853

7. AGE Years 76 Months 4 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Prince Edward Islands

PARENTS

10. NAME OF FATHER Bernard McCabe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Bridget McGurd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Sisters of St Joseph
(Address) Lewiston

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 30, 1930
that I last saw him alive on Jan 30, 1930
and that death occurred, on the date stated above, at 5-15 P m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
2-14, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial 19

20. Undertaker Vissar Mortuary
Address Lewiston

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71809

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44

2. FULL NAME Jack Martin

(a) Residence, No. E. Lewiston St. Kendrick Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Martin

6. DATE OF BIRTH (month, day and year) July

7. AGE Years 37 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS

10. NAME OF FATHER Jake Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Mrs Helen Martin
(Address) Lewiston, Idaho

15. Filed 2-1, 1930 S. E. Bruce Per JMR Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Jan 3, 1930
that I last saw him alive on Jan 3, 1930
and that death occurred, on the date stated above, at 5:59 p. m.

The CAUSE OF DEATH* was as follows:
Primary Carcinoma of Liver.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kendrick, Idaho
Did an operation precede death? Yes Date of Jan 3
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) R. T. Scott, M. D.
, 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 1/5 1930

20. Undertaker Vassar Mortuary — Address Lewiston

white

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71810

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME C. Wayne Palmer

43

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Sept 4th 1889

7. AGE: Years 40, Months 3, Days 26. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS

10. NAME OF FATHER: R. M. Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.
12. MAIDEN NAME OF MOTHER: Julia M Nichols
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: Mrs Kester
(Address) Lewiston Idaho

15. Filed 2-1, 1930 S. E. Bruce Registrar
Per JMK

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 2, 1930
that I last saw him alive on Jan 2, 1930
and that death occurred, on the date stated above, at 8.30 A.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of lower jaw throat + upper rt. jaw
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms (Wassermann neg.)
(Signed) E. L. White, M. D.
1-7, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston
Date of Burial: 19

20. Undertaker: Vassar Mortuary
Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7122

PLACE OF DEATH
County of Nez Perce
City of Lewiston Idaho
Registration District No. 95
Primary Registration District No. 1009
Local Registrar's No.
(No.) 74A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Skinner
(a) Residence. No. Cheney St. Wash
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John Skinner
6. DATE OF BIRTH (month, day and year) Mar 13, 1853
7. AGE Years 77 Months Days 15 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Darmstadt Germany

PARENTS
10. NAME OF FATHER Jacob Balz
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Darmstadt Germany
12. MAIDEN NAME OF MOTHER Anna Balz
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs J. H. Fulton
(Address) Asotin, Wash
15. Filed Jan 16, 1931 Susan E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Elvans M. D.
3/28, 1930 (Address) Asotin Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cheney Wash. Date of Burial: 3/30 1930
20. Undertaker: H R Merchant Address: Clarkston Wash

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7182

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 95
Primary Registration District No. 1009
(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

161a

2. FULL NAME Premature Ralph Kennedy baby

(a) Residence. No. Nez Perce Idaho St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): 3/26/30

7. AGE: Years | Months | Days | If LESS than 1 day, 4 hrs. or 30 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho.

PARENTS

10. NAME OF FATHER: Ralph Kennedy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho.
12. MAIDEN NAME OF MOTHER: Blanche Rowe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nez Perce Idaho

14. Informant: Paul Rowe
(Address): Lewiston Idaho

15. Filed Jan 1, 1930. Ernest E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 27 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1930, to Mar 27, 1930
that I last saw h[illegible] alive on Mar 27, 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Premature Infant
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) V O Clark, M. D.
3/27/30 (Address) Juniata Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nez Perce Idaho — Date of Burial: 3/27 1930
20. Undertaker: Vassar Mortuary — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Carsson

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71822

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

89

2. FULL NAME Chas. L. Gifford

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Gifford

6. DATE OF BIRTH (month, day and year) March 15 - 1861

7. AGE Years 69 Months — Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) Stock & Grain
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER John K Gifford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER Martha Davison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Mary L Gifford
(Address) Lewiston Ida

15. Filed 4-1, 1930 S. E. Bruce Registrar
Per JMR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb, 1927, to Mar 23rd, 1930
that I last saw him alive on Mar 23rd, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) + yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) O C Carsson, M. D.
3/25, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 19

20. Undertaker Vassar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lyle RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71823

PLACE OF DEATH
County of Ney Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

88B

2. FULL NAME E. A. G. Miller
(a) Residence. No. Lewiston St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Miller

6. DATE OF BIRTH (month, day and year) Feb 15 - 1861

7. AGE Years 69 Months 1 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Wm H Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Ida Charks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Paul Miller
(Address) Lewiston

15. Filed 4-1, 1930 S. E. Bruce Per M L Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1930 to Mar. 16, 1930
that I last saw him alive on Mar 16, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis.
..... (duration) ? yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J M Lyle M. D.
3-20, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial 19

20. Undertaker Vassar Mortuary
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7182

RECEIVED SEP 6 1930

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

(No. 513 Delsol Lane.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlotta Elcretta Taylor.

(a) Residence. No. 513 Delsol Lane. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2/2/1856.

7. AGE Years	Months	Days	If LESS than 1. day, hrs. or min.
74.	1.	16.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin.

PARENTS

10. NAME OF FATHER Robert Mason.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.
12. MAIDEN NAME OF MOTHER Mary -----.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Ira Taylor
(Address) Craigmont, Idaho.

15. Filed 4-1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 18th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Mar 10, 1930, to March 18, 1930
that I last saw h[illegible] alive on March 17, 1930
and that death occurred, on the date stated above, at 4:15 P m.
The CAUSE OF DEATH* was as follows:

arterio sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? High blood pressure

(Signed) , M. D.
3/19/30., 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	3/20/30. 1930
20. Undertaker	Address
Brower-Wann Company	Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71825

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 162

2. FULL NAME Lester Peo.

(a) Residence. No. Lapwai Idaho. St. Lapwai Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) 3/15/30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
------	-----	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lapwai Idaho

PARENTS

10. NAME OF FATHER Walter Peo.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Cecila Green
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Walter Peo.
(Address) Lapwai Idaho

15. Filed 4-1, 1930 S. E. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Meh 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Meh 18, 1930, to Meh 18, 1930
that I last saw him alive on Meh 18, 1930
and that death occurred, on the date stated above, at 5-0 m.
The CAUSE OF DEATH* was as follows:
Melena Neonatorum
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul V. Johnson, M. D.
Meh 20, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Slickpoo Idaho	3/19/30 19
20. Undertaker	Address
Vassar Mortuary Inc.	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71826

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

157

2. FULL NAME Nelson T. Zumwalt

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 4/19/1859

7. AGE Years 70 Months 4 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lane County Oregon

PARENTS

10. NAME OF FATHER David Zumwalt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Chlesta Cowan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant A. J. Zumwalt
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930 to Mar 12, 1930
that I last saw him alive on Mar 12, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Gangrene left leg
(duration) ..... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Lyle M.D.
3/14, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Clarkston, Wash. Date of Burial 3/15 1930

20. Undertaker Brower-Wann Co Address Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71827

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Nellie Anna Britton
(a) Residence. No. ..... St. Spalding Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: M. K. Britton

6. DATE OF BIRTH (month, day and year): 5/24/1890.

7. AGE: 39 Years | Months: 9 | Days: 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Gilroy California.

PARENTS

10. NAME OF FATHER: Andrew Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Anna Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: M. K. Britton
(Address): Spalding, Idaho.

15. Filed Jan 1, 1930. Susan E Bruce, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9th (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 9, 1930
that I last saw her alive on March 9, 1930
and that death occurred, on the date stated above, at 2:20 A m.
The CAUSE OF DEATH* was as follows:
apoplexy.
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary): Hypertension & Arteriosclerosis
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
3/10, 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Idaho | Date of Burial: 3/10 1930

20. Undertaker: Brower & Wann E. | Address: Lewiston Idaho

RECEIVED SEP 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7122

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Martin Luther Smith

(a) Residence. No. Butler Bldg., St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 18, 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	10	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired R.R. Employ
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Camas Prairie Ry.

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Henry Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Amanda Watson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Chas Smith.
(Address) Lewiston Idaho

15. Filed Jan 1, 1930 Susan E. Brue
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 19, (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gun shot wound head

Suicide

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Brower Coroner M.D.
2/20/30, 19 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	2/21/30 19
20. Undertaker: Brower-Wann Co.	Address: Lewiston, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71829

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009

Local Registrar's No.

(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Taylor Embry

(a) Residence. No. 1042 N. 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
		married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Embry.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Beaver Creek - Kentucky
(State or country)

PARENTS

10. NAME OF FATHER John Embry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Hume
13. BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or Country)

14. Informant Clay Embry
(Address) Clarkston Wash.

15. Filed Jan 1, 1930 Susan E. Bruce
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1928, to Feb 3, 1930, that I last saw him alive on Feb 2, 1930 and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Uremia
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Clarkston Wash
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Paul W. Johnson, M. D.
Feb 4, 1930 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	2/4 1930
20. Undertaker	Address
A.A. Merchant	Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. RC. 6-25 M. 1-19 SEP 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71830

Local Registrar's No.

Registration District No. 128

Primary Registration District No.

(No. St.)

If death occurs in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs away from usual residence, give facts called for under special information.

1. PLACE OF DEATH

County of Nez Perce

City of near Lapwai Idaho

2. FULL NAME Mary Daniel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6. DATE OF BIRTH 1912
(Month) (Day) (Year)

7. AGE 18 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF Father William Daniel

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Lena Eneas

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Beal
(Address) Lapwai Idaho.

15. Filed July 1930 George Gammond M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-11-1930, to 7-22-1930, that I last saw her alive on 7-22-1930, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gammond M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Juliaetta Cemetery **DATE OF BURIAL** July 24 1930

20. UNDERTAKER Brauer-Mann Lewiston Idaho **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM ... S. FOR 5-25 M. 1-10. SEP 11 1930 Duplicate of 72130

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Nez Perce

City of Sweetwater Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 71334

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Tababoo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1929 (Year)

7. AGE: 1 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: John Tababoo

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth Bronchean

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Gaignard
(Address) Culdesac Idaho.

15. Filed July 1930 George Gaignard M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH 9

16. DATE OF DEATH: 7 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-1- 1930 to 7-19 1930, that I last saw him alive on 7-19- 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pertussis

..... (Duration) ..... yrs. ..... mos. 19 ds.

Contributory (Secondary) Broncho-Pneumonia

..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) George Gaignard M. D.

7/19/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Slickpoo

DATE OF BURIAL: 7/20/1930

20. UNDERTAKER: Brauer-Wann

ADDRESS: Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 66

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township 1 or Village Sweetwater or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Henry Tahaboo
(a) Residence. No. ____ Sweetwater St., ____ Ward.
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

paid 1-14-31

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 1/8 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single
5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: —
6 DATE OF BIRTH (month, day, and year): 1929
7 AGE — Years: 1 | Months: | Days: | If LESS than 1 day, ____ hrs. or ____ min.:
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9 BIRTHPLACE (city or town): Sweetwater
(State or country): Ida
PARENTS
10 NAME OF FATHER: John Tahaboo
11 BIRTHPLACE OF FATHER (city or town): Sweetwater
(State or country): Ida.
12 MAIDEN NAME OF MOTHER: Elizabeth Bruneau
13 BIRTHPLACE OF MOTHER (city or town): Culdesac
(State or country): Ida.
14 Informant: George Daignard
(Address): Culdesac Ida
15 Filed 9/3/, 1930 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1930
17 I HEREBY CERTIFY, that I attended deceased from 7-1-, 1930, to 7-19-, 1930,
that I last saw him alive on 7-19-, 1930,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Pertussis
____ (duration) ____ yrs. ____ mos. 19 ds.
CONTRIBUTORY (SECONDARY) Broncho-pneumonia
____ (duration) ____ yrs. ____ mos. 3 ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) George Daignard, M. D.
9/19, 1930 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lukepoo Cemetery	7-20-1930
20 UNDERTAKER	ADDRESS
Brown-Vann Co	Lewiston

19—8184 GOVERNMENT PRINTING OFFICE

RECEIVED SEP 11 1930

FORM V. S. No. 5-26 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. [illegible]

Local Registrar's No.

1. PLACE OF DEATH

County of Key Pierce

City of Golden Gulch (Spalding) Idaho.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Billie Davis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1851 (Year)

7. AGE: 79 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sophia B. Brentheau
(Address) Spalding Idaho

15. Filed July 1930 George Gaumer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-2-1930, to 7-15-1930, that I last saw him alive on 7-12-1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Rheumatism

.....

.....

(Duration) ..... yrs. mos. 10 ds.

Contributory (Secondary) Pericarditis

(Duration) ..... yrs. mos. 4 ds.

(Signed) George Gaumer M. D.

7/15 1930 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spalding Cemetery — DATE OF BURIAL: July 15 1930

20. UNDERTAKER: F. Brauer-Wann — ADDRESS: Lewiston Idaho

FORM V. S. No. 5-35-M. 1-19. RECEIVED SEP 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Spalding Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 71[illegible]

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Meryle ~~Miles~~ Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 3/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: May (Month) 4 (Day) 1930 (Year)

7. AGE: ..... Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Aggie Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Aggie Miles
(Address) Lapwai Idaho

15. Filed July 1930 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-7-1930, to 7/8-1930, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gastro-Enteritis

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

7/9/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Cemetery

DATE OF BURIAL: July 10 1930

20. UNDERTAKER: Brower-Wann

ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. RECEIVED SEP 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 7109

Local Registrar's No.

Registration District No. 128

Primary Registration District No.

(No. St.)

1. PLACE OF DEATH

County of Nez Perce

City of near Juliaetwater

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: (Month) (Day) 1913 (Year)

7. AGE: 17 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Joseph Williams

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Lucy Newton

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L. Maxwell
(Address): Lapwai, Idaho.

15. Filed July 1930 George Gaumard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH: July (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/24/30 19..., to 7/1/30 19..., that I last saw her alive on 7/1/30 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaumard M. D.
7/1 1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19...

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-18

RECEIVED SEP 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 1

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Nez Perce Registration District No. 128

City of Culdesac Idaho Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marvin Wayne Vawter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1929 (Year)

7. AGE: 1 Yrs. 5 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Arthur Dever Vawter

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Gladys Parks

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Arthur D. Vawter
(Address): Culdesac Idaho

15. Filed July 1930 George Gaumer Local Registrar

MEDICAL CERTIFICATE OF DEATH

186

16. DATE OF DEATH: July (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1930 to July 26 1930, that I last saw him alive on July 26 1930, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Run over by automobile
Chest Crushed

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaumer M. D.
7/26 1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Idaho — DATE OF BURIAL: 7/27/30

20. UNDERTAKER: Family — ADDRESS: Culdesac Idaho

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7182

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2064

Local Registrar's No. 52

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

113

2. FULL NAME Donna Mae Hooper

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 16 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	3	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Vernon Hooper
11. BIRTHPLACE OF FATHER (city or town) Lava
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Elvina E. Holmes
13. BIRTHPLACE OF MOTHER (city or town) Portage
(State or Country) Ut.

14. Informant Vern Hooper
(Address)

15. Filed 8/31, 1930 J. M. Owen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930, to Aug. 18, 1930
that I last saw her alive on Aug. 18, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Enteritis
(duration) ..... yrs. ..... mos. 12 ds.
CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) O. P. Garrett, M. D.
Aug. 14, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lava Hot Spgs Ida	Aug 20 1930
20. Undertaker	Address
J. Guy Henson	Malad Ida

TION is very important. See instruction on back of certificate.

RECEIVED SEP 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1183

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

2. FULL NAME Franklin Opperman

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 14. 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	13	11	19	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho

PARENTS
10. NAME OF FATHER Frank Henry Opperman
11. BIRTHPLACE OF FATHER (city or town) Steamboat point
(State or Country) Iowa
12. MAIDEN NAME OF MOTHER Jemima Stuart
13. BIRTHPLACE OF MOTHER (city or town) Malad
(State or Country) Idaho

14. Informant H. S. Opperman
(Address) Malad Idaho.

15. Filed 8/31, 1930 J. M. Harris Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Aug 12, 1930
that I last saw h— alive on Aug 12, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH was as follows:
Diphtheria
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Epidemic
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Public
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Harris M. D.
8/12, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Idaho	Aug. 14 1930
20. Undertaker	Address
J. Guy Duncan	Malad Idaho

SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71836

PLACE OF DEATH

County of Owyhee

City of Tindall

Registration District No. 74

Primary Registration District No. 2151

Local Registrar's No. 59

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel G. Wallis

(a) Residence. No. Tindell, Owyhee Co Idaho St. 33 years. 197
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54		25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kelso, Quebec Canada

PARENTS

10. NAME OF FATHER Theodore Wallis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Huntingdon County, Canada

12. MAIDEN NAME OF MOTHER Rhoda A. Watier

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montreal, Canada

14. Informant Nellie Chapman
(Address) Shoshone, Idaho

15. Filed Sept. 11, 1930 Wm. J. Erkenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH* was as follows:
A gunshot in the head. Called justifiable homicide by Coroner's jury

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Erkenbeck, M. D.
Sept. 10, 1930 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home, Idaho	Sep. 7th 1930
20. Undertaker C.G. Zacher	Address Mt. Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. .....

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of New Plymouth
Registration District No. 5
Primary Registration District No. 2009 Local Registrar's No. 7
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hugh E Wilfong
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

92

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 25 1880

7. AGE Years 50 Months – Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Sylvester Wilfong
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER France Myers
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kans

14. Informant (Address) Mrs Hugh Wilfong New Plymouth

15. Filed Sept 3, 1930 Wm J Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Aug 30, 1930
that I last saw him alive on Aug 30, 1930
and that death occurred, on the date stated above, at 2a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Coronary thrombosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of no
Was there an autopsy? no
What test confirmed diagnosis? Clinical data
(Signed) W J Weese M. D.
Aug 31, 1930 (Address) Ontario Ore.

19. Place of Burial, Cremation, or Removal Park View N Plymouth Date of Burial 9-2 1930

20. Undertaker J H Adair Address Peterson Furn Co Payette Ida

RECEIVED SEP 1 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Payette
City of Fruitland
New Plymouth Registration District No. 5
Primary Registration District No. 2009 Local Registrar's No. 6
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Harry O Baker

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE~~ of Susie Baker

6. DATE OF BIRTH (month, day and year) June 29 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	2		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Ill

PARENTS
10. NAME OF FATHER Isaac N Baker
11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Ill
12. MAIDEN NAME OF MOTHER Sarah Foot
13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) Ill

14. Informant W. Roy Baker (Address) Fruitland Ore

15. Filed Aug 29, 1930 Wm D Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ ~~1929~~ to ~~Aug 27-1930~~
that I last saw h..... alive on ..... about ....., 19.....
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Death was instantaneous (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? clinical evidence
(Signed) Wm D Drysdale, M. D.
Aug 28, 1930 (Address) New Plymouth

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth	Aug 30 1930

20. Undertaker H H Hudson Address Hudson Funeral Home Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 51
Primary Registration District No. 2130 Local Registrar's No. 4
(No. .....)
(If death occurred in a hospital ~~or institution~~, give its name instead of street and number.)

443

2. FULL NAME Delila H Rich

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
~~(or)~~ WIFE of L H Rich

6. DATE OF BIRTH (month, day and year) May 18 1861

7. AGE Years 69 Months 3 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS
10. NAME OF FATHER Chas Russell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Ill~~ Ind
12. MAIDEN NAME OF MOTHER Harriett Long
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill

14. Informant (Address) Lena A Thompson Fruitland Ida

15. Filed Sept 30, 1930 Mrs Wm J. Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10, 1930, to Aug 28, 1930
that I last saw her alive on Aug 28, 1930
and that death occurred, on the date stated above, at 6 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
(degenerative heart disease)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dementia
..... (duration) ..... yrs. ..... mos. 15 ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) N. J. Weese M. D.
Aug 31, 1930 (Address) Ontario Ore

19. Place of Burial, Cremation, or Removal Payette Ida
Date of Burial Aug 31 1930

20. Undertaker T. H. Adair Address Peterson Furn Co Payette Ida

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71841

PLACE OF DEATH

County of Power

City of American Falls, Ida.

Registration District No. 25

Primary Registration District No. 2079

Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159c

2. FULL NAME Darold Vern Vanderhule

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) July 7, 1930

7. AGE: Years --- Months ---- Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ------

(b) General nature of industry, business, or establishment in which employed (or employer) -----

(c) Name of employer ------

9. BIRTHPLACE (city or town) (State or country) American Falls, Ida.

PARENTS

10. NAME OF FATHER Clarence A. Vanderhule

11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota

12. MAIDEN NAME OF MOTHER Iva Danial

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane, Washington.

14. Informant Clarence A Vanderhule
(Address) American Falls

15. Filed 9-8, 1930 Guenevere Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1930, to July 8, 1930
that I last saw her alive on July 8, 1930
and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:
Congenital deformity - absence of hard & soft palate

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) atelectasis of lung

(duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

7-9, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: American Falls, Ida. Fallsview

Date of Burial: July, 9, 1930

20. Undertaker: A W Davis

Address: American Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7185

County of Power

City of American Falls

Registration District No. 23

Primary Registration District No. 2072

Local Registrar's No. 20

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1880 C

2. FULL NAME Johnanna Larson

(a) Residence. No. Santaquin (Usual place of abode) Utah St.

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Larson

6. DATE OF BIRTH (month, day and year) Feb 14th 1852

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	6	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant E. O. Larson

(Address) 2134 S 8th East Salt Lake City Utah

15. Filed 8/30, 1930. Genevieve Roth, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 29th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Car left standing on high bank on west side of snake river, Car roled to edge of cliff and fell into fore-bay fifty feet below, deceased was only one in car, killed instantly. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Fractured Skull.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. W. Davis Coroner

Aug 30/30, 19 (Address) American Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Santaquin, Utah	19

20. Undertaker A. W. Davis Address Am Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71846

PLACE OF DEATH

County of Power
City of American Falls,

Registration District No. 23
Primary Registration District No. 2072
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

135

2. FULL NAME John Henry Wheeler

(a) Residence. No. 724 Hutchinson Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: THeodosia Wheeler

6. DATE OF BIRTH (month, day and year): Jan 4th 1843

7. AGE: Years 87, Months 7, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mo

PARENTS

10. NAME OF FATHER: Nathon Wheeler
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ky
12. MAIDEN NAME OF MOTHER: Margret Bryce
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Mrs O. F. Crowley,
(Address) American Falls, Idaho

15. Filed 8/23, 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 22nd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Aug 22, 1930
that I last saw him alive on Aug 21, 1930
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Prostatitis & cystitis
(duration) 1 1/2 yrs. mos. ds.
CONTRIBUTORY (Secondary): Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. F. Schiltz, M. D.
8/23, 1930 (Address) Am Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: L.O.O.F Cemetary
Date of Burial: 8-24 1930

20. Undertaker: L. K. Davis
Address: American Falls Idaho

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71848

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

129

2. FULL NAME Josephine M McCormick
(a) Residence. No. Spokane, Wash St. Spokane W 2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John L McCormick
6. DATE OF BIRTH (month, day and year) Jan 30 - 1864
7. AGE 66 Years Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER James A Abbott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Anna M Shelby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky.

14. Informant John L. McCormick
(Address) Wallace, Idaho
15. Filed July 24, 1930 T. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to July 23, 1930
that I last saw her alive on July 23rd, 1930
and that death occurred, on the date stated above, at 4:15 A m.
The CAUSE OF DEATH* was as follows:
Chr Parenchymatous
nephritis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys Exam
(Signed) Max F. Smith M. D.
7/23/30, 19 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash
Date of Burial Shipped July 24-30
20. Undertaker J. A. Bever Ward Undertaking C.
Address Wallace, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1000

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hospital)
Local Registrar's No. 73
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Dewar

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 5 - 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Section hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Northern Pacific R.R.

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER Andrew Dewar
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Ellen Maher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs Wm T Dewar
(Address) Wallace Idaho.

15. Filed July 22, 1930 E. R. Langley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/15, 1930, to 7/20, 1930, that I last saw h[e] alive on July 19, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Beam, M. D.
7/21/30 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Missoula Mont.	July 22 1930
20. Undertaker J. A. Swee	Address
Ward Ward Co.	Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71059

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 72

129

2. FULL NAME Elizabeth E Thompson
(a) Residence. No. 614 E. Bank St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) June 5 - 1855

7. AGE 75 Years | Months 1 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Christopher Schimpf
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Marguerite Grosgrill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs E Ward
(Address) Wallace Idaho

15. Filed July 22, 1930 F. L. Reed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1930 to July 18, 1930
that I last saw her alive on July 18, 1930
and that death occurred, on the date stated above, at 9:15 P m.
The CAUSE OF DEATH* was as follows:
Interstitial Nephritis
Chronic
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Personal history & Lab. findings
(Signed) J. J. Burns M. D.
July 19, 1930 (Address) Spokane Wn.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho | Date of Burial July 22 1930

20. Undertaker J. A. Bever Ward Und. Co. | Address Wallace Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

109B

2. FULL NAME Maud Hellen Duthie
(a) Residence. No. 63 - Mullan Road St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frank Duthie

6. DATE OF BIRTH (month, day and year) Jan 25 - 1888

7. AGE Years 42 Months 5 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Helena Mont.

PARENTS
10. NAME OF FATHER John Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Mr Frank Duthie
(Address) Wallace, Idaho

15. Filed July 19, 1930 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1930, to July 11, 1930
that I last saw her alive on July 11, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Epithelioma of pharynx
..... (duration) ..... yrs. 3 mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 9 '30
Was there an autopsy? No
What test confirmed diagnosis? Microscopical examination
(Signed) Arthur C Jordan, M. D.
July 18 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho — Date of Burial July 19 1930

20. Undertaker J. A. Bever Ward Und Co. — Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED [illegible] 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

90

2. FULL NAME Sauco Turno
(a) Residence. No. Kellogg, Ida. St. Kellogg, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year)

7. AGE About 50 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Austria.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Records at Hosp.
(Address) and Sheriff Office - Shoshone Co.

15. Filed July 20, 1930 S. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about May 15, 1930, to July 16, 1930
that I last saw him alive on July 15, 1930
and that death occurred, on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Chr. Valvular Heart
(duration) years yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
7/18/30, 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho | Date of Burial July 20 1930

20. Undertaker J. A. Bever Ward Und Co. | Address Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 11933

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 10
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 69

2. FULL NAME William McCullough

(a) Residence. No. Mullan Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Mary McCullough

6. DATE OF BIRTH (month, day and year) Oct 15 - 1865

7. AGE: 64 Years | 6 Months | 28 Days | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: Sam McCullough
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland.
12. MAIDEN NAME OF MOTHER: Mary Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs Mary McCullough
(Address): Mullan Ida

15. Filed July 16, 1930 J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1930 to July 13, 1930
that I last saw ~~him~~ alive on July 13 - 1930
and that death occurred, on the date stated above, at 11:00 A m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(duration) 2 yrs. 4 mos. 10 ds.
CONTRIBUTORY (Secondary) Hemorrhage - Pul - monary (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ~~X~~
Did an operation precede death? No Date of ~~X~~
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) ~~X~~ [illegible] M. D.
July 14, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Mullan Idaho — Date of Burial: July 16 1930
20. Undertaker: J A Burer Ward Und Co — Address: Wallace, Idaho

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. 66 Bitterroot)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

2. FULL NAME Edward W. Browne

(a) Residence. No. Rural Idaho St. Gene Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Clovie Brown

6. DATE OF BIRTH (month, day and year) Oct. 15 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	9	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) Theda Mine
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Town - Montana

PARENTS

10. NAME OF FATHER Frank Dean Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Anna Marie Lenz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Mrs Clovie Brown
(Address) Wallace Idaho

15. Filed July 11, 1930 A. R. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to 7/10/30, 19...
that I last saw him alive on 7/9/30, 19...
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 1 yrs. [illegible] mos. ds.

CONTRIBUTORY (Secondary) Chronic Dilicosis

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Bean, M. D.
7/10/30, 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, ~~or Removal~~	Date of Burial
Spokane Wash.	July 11 1930
20. Undertaker	Address
Ward Und Co.	Wallace Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71015

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
Local Registrar's No. 67

(If death occurred in a hospital or institution, give its name instead of street and number.)

146 e

2. FULL NAME Wm Howard Moore

(a) Residence. No. Cottage Grove St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Clara Moore

6. DATE OF BIRTH (month, day and year) Oct 30 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer) Leasing.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mrs Clara Moore
(Address) Wallace, Idaho.

15. Filed July 17, 1930 J. B. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1930 to July 5 1930
that I last saw him alive on July 5 1930
and that death occurred, on the date stated above, at 10:45 a m.
The CAUSE OF DEATH was as follows:
Killed by coal mine cave in
(duration) yrs. 5 minutes
CONTRIBUTORY (Secondary) Auto accident
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Dr Moore
(Signed) Dr Moore, M. D.
7/8, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shipped to Grand Forks BC | Date of Burial: July 12 1930
20. Undertaker J. A. Brown Ward & Lund Co. | Address: Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 66

184 c

2. FULL NAME Richard Daniels
(a) Residence. No. near Taft, Mont. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Francis M. Daniels

6. DATE OF BIRTH (month, day and year) June 9 1859

7. AGE: Years 70, Months 1, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Peoria Illinois

PARENTS

10. NAME OF FATHER: Michael MacDray
11. BIRTHPLACE OF FATHER (city or town) (State or Country): not known
12. MAIDEN NAME OF MOTHER: Mary Hooker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scandy Kansas ~~not known~~

14. Informant: C H Daniels
(Address): Superior Mont

15. Filed 7-10, 1930. F. L. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jul (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 8, 1930 to Jul 8, 1930
that I last saw him alive on Jul 8, 1930
and that death occurred, on the date stated above, at 3:30 p.m.
The CAUSE OF DEATH* was as follows: Fracture Skull & Jaw
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Auto upset Acci
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dex Mowery, M. D.
7/9, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Superior, Mont. Date of Burial: July 10th 1930

20. Undertaker: Bruce G. Norstell Address: Wallace

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71957

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 65

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1010

2. FULL NAME George F. Shull

(a) Residence. No. 1 mile west of Wallace
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Cora Shull

6. DATE OF BIRTH (month, day and year) Feby 22 1862

7. AGE Years 68 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) near Pilot Rock Oregon

PARENTS

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (city or town) (State or Country) not given " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Bert Trowbridge
(Address) Wallace Idaho

15. Filed 7-8, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jul (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jul 3, 1930 to Jul 5, 1930

that I last saw him alive on Jul 5, 1930

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobular both lungs

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) alcoholism

(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Des Morwell, M. D.

7/7, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho Date of Burial July 8th 1930.

20. Undertaker B. G. Worstell Address Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED AUG 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71855

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

151

2. FULL NAME George Luzerne Lucas
(a) Residence. No. East Canyon Ave.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice M. Lucas

6. DATE OF BIRTH (month, day and year) Aug 27 1848

7. AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ashtabula Ohio

PARENTS

10. NAME OF FATHER George T. Lucas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER Amanda Darrow
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant Geo D. Lucas
(Address) 31 Burke Road Wallace

15. Filed 7-3, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to July 1, 1930
that I last saw him alive on July 1, 1930
and that death occurred, on the date stated above, at 6 20/9 m.
The CAUSE OF DEATH* was as follows:
Senile Gangrene both feet & legs
(duration) yrs. Several mos. ds.
CONTRIBUTORY (Secondary) arteriosclerosis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? None
What test confirmed diagnosis? None
(Signed) Dr. Mowery, M. D.
7/2, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane. Wash
Date of Burial July 3 1930

20. Undertaker Bruce G. Worstell
Address Wallace

FORM V. S. No. 3-2 M. 1-16-13 RECEIVED SEP 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. ..... St.)

File No. 71859
Registered No. 84

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH. 12 (Month) 15 (Day) 1846 (Year)

7. AGE 83 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Norway.

10. NAME OF FATHER Thomas Larson

11. BIRTHPLACE OF FATHER (State or Country) Norway.

12. MAIDEN NAME OF MOTHER ——

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. M. Rogers
(Address) County Infirmary

15. Filed Sept 3 1930 A. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-17-29 191..., to 8-29- 1930, that I last saw him alive on 8-28- 1930 and that death occured on the date stated above, at 2:30 M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Years ..... mos. ..... ds.

(Signed) James R. Bean M. D.

8/30 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 5 mos. 12 days. In the State 4 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Burke Ida.

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho
DATE OF BURIAL: Aug 30

20. UNDERTAKER: M. C. Thornhill
ADDRESS: Kellogg, Idaho

SYMS - YORK CO., PTRS. & BDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

PLACE OF DEATH

County of Shoshone

City of Wallace

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71864

Registration District No. 70

Primary Registration District No. 1011

Local Registrar's No. 83

(No. Wallace Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter J. Shoup

(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lena Shoup

6. DATE OF BIRTH (month, day and year) Dec 7 1897

7. AGE 32 Years | Months 7 | Days 24 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Coeur d'Alene Hdw. Co.

9. BIRTHPLACE (city or town) (State or country) Salmon Idaho

PARENTS

10. NAME OF FATHER William H. Shoup

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salmon Idaho

12. MAIDEN NAME OF MOTHER Jessie Richardson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Deer Lodge Mont.

14. Informant Mrs Wm H. Shoup

(Address) Wallace, Idaho

15. Filed Sept 3, 1930 J. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 30, 1930

that I last saw him alive on Aug 30, 1930

and that death occurred, on the date stated above, at 5 AM m.

The CAUSE OF DEATH* was as follows:

Septicemia (generalized)

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture spinal puncture

(Signed) Paul McEllis, M. D.

Aug 31, 1930 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal Salmon Idaho | Date of Burial Sept 3 1930

20. Undertaker J. A. Bever Ward Und. Co. | Address Wallace, Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. 60 Infirmary St.)

File No. 71862

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Black

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE About 80 years Yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. N. Rogers

(Address) County Infirmary

15. Filed Aug 31 1930 F. L. Tingley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) 30 (Day) 1930 (Year) 129

17. I HEREBY CERTIFY, That I attended deceased from 2-19- 1930, to 8-30- 1930, that I last saw her alive on 8-29- 1930, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) Years Yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis

(Duration) Years yrs. mos. ds.

(Signed) James R Bean M. D.

8/30 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 6 mos. 11 days. In the State 40 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Gem Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho

DATE OF BURIAL Aug 31 1930

20. UNDERTAKER J. A. Bever Ward Mfd Co.

ADDRESS Wallace Ida.

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 20
Primary Registration District No. 2011
Local Registrar's No. 81
(No. Providence Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16/20

2. FULL NAME Delno Burns

(a) Residence. No. Wallace, Idaho St. Mullan Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male ~~Female~~
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 19 30

7. AGE Years | Months | Days | If LESS than 1 day, 45 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace, Idaho

PARENTS

10. NAME OF FATHER George Burns
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Dollie Childers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Mr George Burns
(Address) Mullan, Idaho.

15. Filed Aug 20, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/19/30, 19..., to 8/19/30, 19...
that I last saw h... alive on 8/19/30, 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Asphyxia

... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Bean, M. D.
8/19/30, 19... (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	Aug 20 1930
20. Undertaker J. A Bower	Address
Ward Funeral Co.	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71003

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 80

188c

2. FULL NAME John Frazier Ferguson.
(a) Residence. No. 185 King St St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Zoe Ferguson

6. DATE OF BIRTH (month, day and year) Feby 12 1890

7. AGE Years 40 Months 6 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pittsburg Pa.

PARENTS

10. NAME OF FATHER John Frazier Ferguson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Cecilia Anne Clancy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant
(Address) Zoe Ferguson

15. Filed Aug 20, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Aug 17, 1930
that I last saw him alive on Aug 17, 1930
and that death occurred, on the date stated above, at 1 P m.
The CAUSE OF DEATH* was as follows:
Fracture of base of skull sustained in automobile accident
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? physical examination Spinal puncture
(Signed) Paul W. Ellis, M. D.
Aug 18, 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane Wash
Date of Burial Aug. 20 1930

20. Undertaker Bruce G. Worstell
Address Wallace

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7196

Local Registrar's No. 79

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. Wallace Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

197

2. FULL NAME Charles Nelson (Warden)

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 55.			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant No One.

(Address)

15. Filed Aug 22, 1930 J. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 11 PM, 1930, to Aug 16 1 30 AM, 1930

that I last saw him alive on Aug 16, 1930

and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Gunshot wound in abdomen + left arm, homicidal, in attempted escape from officers.

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? physical examination

(Signed) Paul W. Ellis, M. D.

Aug 16, 1930 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or ~~Removal~~	Date of Burial
Wallace Idaho	Aug 22 1930
20. Undertaker J. A. Boyer Ward and Co.	Address Wallace Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71865

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 78

2. FULL NAME Marion Elmer Gilliland

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Gilliland

6. DATE OF BIRTH (month, day and year) Dec 29 - 1892

7. AGE 37 Years | Months 7 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER N. B. Simpson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Carrie Hall
13. BIRTHPLACE OF MOTHER (city or ~~town~~) (State or Country) Ill.

14. Informant George Gilliland
(Address) Wallace, Idaho.

15. Filed Aug 19, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1930, to Aug 16, 1930
that I last saw him alive on Aug 16, 1930
and that death occurred, on the date stated above, at 4:15 P m.
The CAUSE OF DEATH* was as follows:
Septicaemia

..... (duration) ..... yrs. Several mos. ..... ds.

CONTRIBUTORY (Secondary) Miscarriage

..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Not Date of Aug 8
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. A. Monfarell M. D.
Aug 18, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. | Date of Burial Aug 19 1930

20. Undertaker J. A. Bever Ward Und Co. | Address Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71866

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 77

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

4810

2. FULL NAME Martha Caroline Ansell

(a) Residence. No. 1125 Canyon Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16 - 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Dunn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Zerilda Baichbridge

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Hallie Ansell
(Address) Wallace, Idaho.

15. Filed Aug 17, 1930 D. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 14, 1930
that I last saw her alive on Aug 14, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chr Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phy Exam
(Signed) Wm. T. Brown M. D.
8/16/30, 19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Idaho.	Aug 17 1930
20. Undertaker J. A Bever Ward Und Co.	Address Wallace, Ida

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71867

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 20
Primary Registration District No. 1011
(No. Providence Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

2. FULL NAME John Edward Ryan
(a) Residence No. Pine St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan. 22 - 1901
7. AGE Years 29 Months 6 Days 18 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Accountant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER John Ryan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Katie McGraw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Miss Elsie Ryan
(Address) Wallace, Idaho
15. Filed Aug 12, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Aug 10, 1930
that I last saw him alive on Aug 10, 1930
and that death occurred, on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Septicaemia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Appendicitis Gon-
greefore (duration) yrs. mos. 7 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 5
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowery M. D.
8/11, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, [redacted] Wallace, Idaho — Date of Burial Aug 12 1930
20. Undertaker J. A. Beer Ward Und Co. — Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 75

101 a

2. FULL NAME Edward J. Duff
(a) Residence. No. Woodland Park St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Theresa Duff

6. DATE OF BIRTH (month, day and year) Sept 1-1877

7. AGE Years 52 Months 11 Days 0 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Leasing.

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Thomas Duff.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Ellan McGraw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Micheal Duff
(Address) Butte, Mont.

15. Filed Aug 4, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Aug 1st 1930
that I last saw him alive on Aug 1st 1930
and that death occurred, on the date stated above, at 4:30 P.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ___ yrs. ___ mos. ___ ds.
CONTRIBUTORY (Secondary) Pneumoconiosis
(duration) 10 yrs. ___ mos. ___ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Exam
(Signed) Max T. Smith M.D.
8/2/30, 19__ (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho — Date of Burial Aug 4 1930

20. Undertaker J. A. Bever Ward Und. Co. — Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7180

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 43

(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Stein (a twin)

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 17, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS

10. NAME OF FATHER Edward Stein
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Valerina Zoellner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oregon

14. Informant Edward P Stein
(Address) Kellogg Idaho

15. Filed 8/30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930, to Aug 20, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 3, P. m.
The CAUSE OF DEATH* was as follows:

Hemorrhage of Stomach.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. P. Mason, M. D.
Aug 28, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Aug 30, 1930
20. Undertaker	Address
M. P. Thornhill	Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED SEP 6 1930

PLACE OF DEATH

County of Shoshone

City of Wardner

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71[illegible]

Registration District No. 123

Primary Registration District No. 2201

Local Registrar's No. 42

(No. [illegible])

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Susan Elizabeth Rodgers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C. P. Rodgers

6. DATE OF BIRTH (month, day and year) Sept. 30, 1847

7. AGE Years 82 Months 10 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Thomas Jefferson Carr

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Nancy Tilford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Bertha Arnold
(Address) Wardner Idaho

15. Filed 8/30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10th, 1930, to Aug 12th, 1930.

that I last saw her alive on Aug 11th, 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Old Age.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) W. C. Lindsay, M. D.

8/13, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kellogg Ida

Date of Burial Aug 14, 1930

20. Undertaker M. C. Thornhill

Address Kellogg Ida

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No.)
Local Registrar's No. 41

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Harriet Mohata Juenniss

(a) Residence. No. 6 West Mission St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. ~~Single, Married,~~ Widowed, or Divorced (write the word)
female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 10 - 1922

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	7	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Craigmont Ida

PARENTS

10. NAME OF FATHER Archie M Juenniss

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clinton Wash

12. MAIDEN NAME OF MOTHER Bertha

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) East Gordon Norway.

14. Informant Archie M Juenniss
(Address) Kellogg Idaho

15. Filed 8/30, 1930 Mrs. Helen M Bride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Aug 4, 1930, that I last saw he alive on Aug 3, 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:
Heart Trouble / Mitral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism + Chorea

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) T. R. Mason, M. D.
Aug 7, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Craigmont Ida	Aug 9 1930
20. Undertaker: Clyde Clowes	Address: Craigmont Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Teton
City of Chapin, Ida

Registration District No. 77
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 71873
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claud Woolstenhulme

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. November (Month) 8 (Day) 1921 (Year)

7. AGE 8 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Samuel Woolstenhulme

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Lizzie Murphy

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lizzie Woolstenhulme
(Address) Victor, Idaho

15. Filed 8-20- 1930 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

48 B

16. DATE OF DEATH July (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1930, to July 3 1930, that I last saw him alive on July 3 1930, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis

(Duration) Yrs. 4 mos. ..... ds.

Contributory (Secondary) Nephritis

(Duration ..... yrs. 2 mos. ..... ds.

8/1 1930 (Signed) Louis X Rich M. D.
(Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho
DATE OF BURIAL: 7-6- 1930

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24653

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71874

PLACE OF DEATH

County of Twin Falls
City of Kimberly

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

113

2. FULL NAME Gerald Emeny Douglass

(a) Residence. No. K Kimberly St.
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Opal O Douglass

6. DATE OF BIRTH (month, day and year) Nov. 7 - 1893

7. AGE	Years	Months	Days	If LESS than 1 day,
	36	9	24	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Meat cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor - Meat Mkt.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pueblo, Colo.

PARENTS

10. NAME OF FATHER George Gardner Douglass

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Madge Elder.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Schuyler, Nebraska

14. Informant (Mrs) Opal O Douglass
(Address) Kimberly Idaho.

15. Filed Sept 5 '30 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930 to Aug 31, 1930
that I last saw ~~him~~ alive on Aug 31, 1930
and that death occurred, on the date stated above, at 5-30 P m.
The CAUSE OF DEATH* was as follows:

Influenza -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical

(Signed) J M Davies, M. D.
Sept 1 - 1930 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	9-3 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED SEP 10 1930

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No.) 124
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Aleese Gooch

(a) Residence. No. ✓ St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of CarlM Gooch

6. DATE OF BIRTH (month, day and year) Nov.14 1904

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	9	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Dayton
(State or country) Idaho

PARENTS

10. NAME OF FATHER Lorenzo M Perkins
11. BIRTHPLACE OF FATHER (city or town) Hooper
(State or Country) Weber CO Utah
12. MAIDEN NAME OF MOTHER Sarah M Callan
13. BIRTHPLACE OF MOTHER (city or town) Brigham City
(State or County) Box Elder Co Utah.

14. Informant Carl M Gooch
(Address) Murtaugh Ida

15. Filed Sept 5 1930 Elizabeth J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug.31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Aug 31, 1930
that I last saw her alive on Aug. 31 1930
and that death occurred, on the date stated above, at 1.30A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Appendicitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Aug 30. 1930
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) Alex Campbell M. D.
Aug 31, 1930, (Address) Twin Falls Ida.

19. Place of Burial, Cremation, or Removal DaytonIda — Date of Burial Sept.3 19

20. Undertaker White Mortuary Inc. — Address Twin Falls.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71876

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) 113
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Archie Fredrick Stuart
(a) Residence. No. Twin Falls St. Dr Leets
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 21/30
7. AGE Years — Months — Days 9 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Idaho
PARENTS
10. NAME OF FATHER N P. Stuart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Ima Stuck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) NY
14. Informant N P. Stuart
(Address) Twin Falls.
15. Filed Sept 5, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 29 1930 (Month) (Day) (Year) 3-30
17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Aug 29, 1930
that I last saw him alive on Aug 28, 1930
and that death occurred, on the date stated above at 2:30 AM
The CAUSE OF DEATH* was as follows:
Enteritis
(duration) yrs. mos. 6 hrs ds.
CONTRIBUTORY (Secondary) none known
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H M Leeton, M. D.
8-29-1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer Cemetery — Date of Burial: Aug 30 1930
20. Undertaker: F E Drake — Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71[illegible]

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No.

(No. Twin Falls Ida. Route #3)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44B

2. FULL NAME Marry L. Lemen

(a) Residence. No. Twin Falls, Ida. Route #3 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 1 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 9th 1852

7. AGE 78 Years Months 20 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER Abraham McCellan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Marry Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant W.A. Pickett
(Address) Twin Falls Ida. Route #3

15. Filed Sept. 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 29th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1930, to Aug 29th 1930 that I last saw her alive on Aug 27th, 1930. and that death occurred, on the date stated above, at 715A m.

The CAUSE OF DEATH* was as follows:

Chronic myo-carditis

Several

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Laughlin M. D.

8-29, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gordon, Neb. Date of Burial 19

20. Undertaker P.J. Grossman Address

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7187

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital) Local Registrar's No. 144
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fern Becher Rook

(a) Residence. No. 711 - 3rd Ave N. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles W. Rook

6. DATE OF BIRTH (month, day and year) Dec 29 - 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logansport Indiana

PARENTS

10. NAME OF FATHER George L. Becher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Sarah E. Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Chas W. Rook
(Address) 711 - 3rd Ave N.

15. Filed Sept. 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to Aug. 28, 1930
that I last saw her alive on Aug 28, 1930
and that death occurred, on the date stated above, at 4:30 P. m.
The CAUSE OF DEATH* was as follows:
Intraperitoneal Hemorrhage
(duration) yrs. mos. 5 hrs
CONTRIBUTORY (Secondary) Ectopic gestation
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 8/28/30
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
8/30, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls Cemetery	
20. Undertaker	Address
White Mortuary Inc	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7187

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jolena Combs Smith

(a) Residence. No. 147 - 7th Ave E St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. Genas Smith

6. DATE OF BIRTH (month, day and year) Aug 14 - 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	0	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rising City Neb.

PARENTS
10. NAME OF FATHER James W. Combs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clay Co. Indiana
12. MAIDEN NAME OF MOTHER Alma Virginia Redden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant W. J. Smith
(Address) Twin Falls, Ida.

15. Filed August 28th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Aug (Day) 25, (Year) 30.

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1928 to July, 1930, that I last saw h[illegible] alive on July 31, 1930, and that death occurred, on the date stated above, at 5. P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma right breast
Metastasis to lungs
Pneumonia right lung
Pleurisy

(duration) 2 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death.
Did an operation precede death? Yes Date of Dec. 5, 1927.
Was there an autopsy? Yes Findings Surgical and Laboratory
What test confirmed diagnosis?

(Signed) W. F. Larsen M. D.
Aug 26 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida	8-27 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7188

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Calla Fahrney

(a) Residence. No. 761 - 2nd N. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ella E. Fahrney

6. DATE OF BIRTH (month, day and year) Oct 4 - 1855

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9. BIRTHPLACE (city or town) (State or country) Maryland
10. NAME OF FATHER Samuel Fahrney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Hannah Durnbaugh
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14. Informant Mrs. Ella E. Fahrney
(Address) 761 - 2nd N. Twin Falls

15. Filed August 28th, 1930. Elizabeth D. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1926, to 8/21, 1930
that I last saw him alive on 8/21, 1930
and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis.
(suppurative)
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Prostatitis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 1926
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
8/27, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	8-25-1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 37

County of Twin Falls

Primary Registration District No. 1085

City of Twin Falls

(No. 216 Main No. St.)

File No. 71881

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Hewitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1930 (Year)

7. AGE 65 Yrs. 11 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wis.

10. NAME OF FATHER Patrick Hewitt

11. BIRTHPLACE OF FATHER (State or Country) Irland

12. MAIDEN NAME OF MOTHER Bridget Reedy

13. BIRTHPLACE OF MOTHER (State or Country) Irland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Frank Wagner

(Address) 216 Main No

15. Filed August 23rd 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH Aug. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1930, to Aug 20th 1930, that I last saw him alive on Aug 20th 1930, and that death occured on the date stated above, at 1205 M.

The CAUSE OF DEATH* was as follows: Chronic Valvular heart disease

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Cerebral hemorrhage Thrombosis of rt popliteal artery

(Duration) Yrs. mos. 12 ds.

(Signed) John H. Vaughn M. D.

8/21 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls

DATE OF BURIAL Aug. 22 1930

20. UNDERTAKER P.J. Grossman Twin

ADDRESS Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24653

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71882

PLACE OF DEATH
County of Twin Falls
City of Kimberly

Registration District No. 37
Primary Registration District No. 2081
(No.) 196
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME J. F. Hamby
(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Unknown 1863
7. AGE: 67 Years — Months — Days — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer: Curtis Bowers
9. BIRTHPLACE (city or town) (State or country): N C

PARENTS
10. NAME OF FATHER: Joe Hamby
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N C
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: J. R. Hamby
(Address) Kimberly

15. Filed Aug-22nd, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Accidental Electrocuted High Power Contact Moving derrick under line 7 miles So. Kimberly yrs. mos. ds.
CONTRIBUTORY (Secondary): Killed instantly
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No No Result
What test confirmed diagnosis? Artificial Respiration
(Signed) F. E. Drake Coroner, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Aug. 20 1930
20. Undertaker: F. E. Drake — Address: Twin Falls

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71883

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.
(No. Co Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

95

2. FULL NAME Franklin Martin
(a) Residence. No. Blackfoot Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Flora Martin
6. DATE OF BIRTH (month, day and year) May 22 1880
7. AGE: Years 50 Months 2 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auto Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS
10. NAME OF FATHER Henry Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Mrs. Franklin Martin
(Address) Blackfoot Idaho
15. Filed Aug 22nd, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 15 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug. 15, 1930, to Aug. 15, 1930.
that I last saw him alive on Aug. 15, 1930.
and that death occurred, on the date stated above, at 1:30 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
One hour (duration) ~~yrs.~~ ~~mos.~~ ~~ds.~~
CONTRIBUTORY (Secondary)
Hypertension (duration) ten yrs. Twin Falls, Ida.
18. Where was disease contracted if not at place of death? 154 - Main Ave. N.
Did an operation precede death? No Date of — —
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms.
(Signed) N. F. Passer M. D.
Aug. 15, 1930. (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Blackfoot Ida
Date of Burial 19
20. Undertaker: J. G. Grossman
Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7188

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME Jas Oconnor

(a) Residence. No. Silt Colo St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	.....

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work b Station Agent at Silt Colo
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer D$R G

9. BIRTHPLACE (city or town) (State or country) U nknown

PARENTS

10. NAME OF FATHER Oconnor

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant F E Drake County Coroner
(Address) Twin Falls Idaho

15. Filed Aug. 22nd 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August, 13/3 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

SUICIDE
By inhaleing gass from exhaust of car thru hose caried into car
(duration) ..... yrs. ..... mos. ..... ds.
doors closed, left note
CONTRIBUTORY (Secondary) stating premeditated
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ,,,,,,,
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? general test

(Signed) F E Drake Coroner, M. D.
....., 19..... (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fort Morgan Colo	19
20. Undertaker F E Drake	Address A

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71885

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

45

2. FULL NAME John Noble
(a) Residence. No. Twin Falls County Hospital St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: 75 Years | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: No.
(Address)

15. Filed August 15th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 12 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept., 1928, to Aug. 12, 1930
that I last saw him alive on Aug. 11, 1930
and that death occurred, on the date stated above, at 1.30 P. m.
The CAUSE OF DEATH* was as follows:
Metastatic carcinoma of bowels
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary): Carcinoma of leg
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 6/18/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
8/14, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer | Date of Burial: Aug 14 1930
20. Undertaker: F. E. Drake | Address: Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71886

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No.

(No.) 114
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Berett Nielson Dr Lamb
(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 3/28
7. AGE Years 2 Months 3 Days 8 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER L. F. Nielson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Ora Posey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant L. F. Nielson
(Address) Twin Falls

15. Filed August 15, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Aug 11, 1930
that I last saw him alive on Aug 11, 1930
and that death occurred, on the date stated above, at 6:30 a m.
The CAUSE OF DEATH* was as follows:
diarrhea
3 weeks (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? E. regular
(Signed) H. O. Lamb (M. D.)
8-12-, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Basin Ida Date of Burial Aug 12 1930
20. Undertaker T. E. Drake Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Oct 18 1928

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71887

PLACE OF DEATH

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No.

(No. Co Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Hazel Hull

(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 7 1902

7. AGE Years 28 Months 1 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Nick Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.

12. MAIDEN NAME OF MOTHER Belle Hittle

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs. Belle Smith
(Address) 315 2nd Ave North City

15. Filed August 22nd 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18th, 1928, to Aug 7th, 1930 that I last saw her alive on Aug 7th, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Interstitial Ch Nephritis with acute exacerbation, Mitral Stenosis with dilatation and hypertrophy (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia (duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H. E. Lamb M. D.

Aug 12th 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls August 12 | Date of Burial Aug 10 1930

20. Undertaker P. J. Grossman | Address Twin Falls

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71888

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2083
Local Registrar's No. 1180
(No. County Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roy Kemp
(a) Residence. No. Hansen, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17th. 1881

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48		8	17	

8. OCCUPATION OF DECEASED Farmer
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Farming for himself

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS

10. NAME OF FATHER John Kemp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Roy Kemp
(Address) Hansen, Idaho

15. Filed August 13th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Aug (Day) 4 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1930 to Aug 4, 1930
that I last saw h-i alive on Aug 4 —, 1930
and that death occurred, on the date stated above, at 12 / 20 A m.
The CAUSE OF DEATH* was as follows: Intestinal Obstruction from adhesions
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 27-30 Aug 4-30
Was there an autopsy? yes
What test confirmed diagnosis? Clinical and operation
(Signed) J. A. Davis, M. D.
Aug 4, 30 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho	Aug 6th 1930
20. Undertaker P.J. Grossman	Address Twin Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71889

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

177

2. FULL NAME Arthur Fred Brongard

(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 1929.

7. AGE: Years 1 | Months May | Days 30 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Filer Idaho.

PARENTS

10. NAME OF FATHER Fred H. Brongard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greeley, Colo.

12. MAIDEN NAME OF MOTHER Mary Kurtz.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lucca, N. Dak.

14. Informant Marie M. Brongard
(Address)

15. Filed August 8th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3, 1930, to August 3 1930 that I last saw him alive on August 30, 1930 and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:
(accident)

Convulsions (duration) One hour. mos. ds.

CONTRIBUTORY (Secondary) Strychnine poisoning. (duration) Two hours mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical

(Signed) F. A. Dwight M. D.
Aug. 3, 1930 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. accident.

19. Place of Burial, Cremation, or Removal: Filer. Date of Burial: Aug 7 1930

20. Undertaker: F. E. Drake Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71896

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 57
Primary Registration District No. 1085
Local Registrar's No.
(No. 182)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edgar Messner
(a) Residence. No. Twin Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 27 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	2	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER P A Messner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Ellen Clemans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N Dakota

14. Informant P A Messner
(Address) Kimberly Idaho

15. Filed July 31 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning in Perrine Lateral 3 Miles East (duration) 1 yrs. mos. ds.
CONTRIBUTORY 3 Miles South of Twin Falls
(Secondary) in water about 4 hours before found (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) T E Drake Coroner
June 23, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	June 23 1930

20. Undertaker T E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice Grant 46
(a) Residence. No. 501 Eleventh Ave. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. 6 mos. 5 ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Aug. 16, 1873

7. AGE Years 57 Months — Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Clinton, Mo.

PARENTS
10. NAME OF FATHER John Grant
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓

14. Informant (Address) A C Lathrop Buhl

15. Filed 9-3 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 2 1929, to Aug 31 1930
that I last saw her alive on Aug 30 1930
and that death occurred, on the date stated above, at 11 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Uterus.

..... (duration) about 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Cancer of Rectum
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Mar. 2. 1929
Was there an autopsy? No.
What test confirmed diagnosis? Clinical & Lab.
(Signed) J. H. Murphy M. D.
Sept. 3, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Date of Burial 9/3 1930

20. Undertaker L. J. Johnson Address Buhl Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED SEP 6 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of Burke.

Registration District No. 39
Primary Registration District No. 7081 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orville Malby 46

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 18 - 1905

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Linn, Kans

PARENTS

10. NAME OF FATHER R. C. Malby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Mabel VanCotton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kans.

14. Informant John Glauden Castleford
(Address)

15. Filed Aug 11, 1930. J. A. Markley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
ascending Pneumonia
while Bathing in Bandywas,
Nytown Nwest of Burke
Found dead (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) F. E. Drake Coroner, M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Linn Kans	
20. Undertaker L. Johnson	Address Burke

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of Tw. Co. Hospital

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Esther Crawford 148
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. R. Crawford

6. DATE OF BIRTH (month, day and year) Nov. 9 - 1894

7. AGE Years 35 Months 9 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER D. W. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Calif
12. MAIDEN NAME OF MOTHER Mary Maxwell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) J. R. Crawford Buhl Ida

15. Filed 8-23, 1930 J. H. Wardley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22, 1930, only, 19.....
that I last saw her alive on Aug 22, 1930
and that death occurred, on the date stated above, at 1:45 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Eclampsia

..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Pregnancy & Acute nephritis
..... (duration) ..... yrs. 8 mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Blood pressure & dis. syn.
(Signed) A. A. Morrison, M. D.
Aug 22, 1930 (Address) Buhl, Idaho

19. Place of Burial, Cremation, or Removal Buhl Ida Date of Burial 8/26 1930

20. Undertaker L. J. Johnson Address Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71991

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2-087
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs Lora Littlefield Hoffa

(a) Residence. No. Buhl Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of

6. DATE OF BIRTH (month, day and year): Jan-30-1840

7. AGE: Years 90 | Months 6 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Maine

PARENTS

10. NAME OF FATHER: Littlefield
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Susan Roberts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant: x Elbert P. Hoffa
(Address): Buhl Idaho

15. Filed 8-15, 1930. J. H. Wakefield Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11 to ....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Autopsy

(Signed) J. H. Wakefield Registrar M. D.
8-15 1930 (Address) Buhl Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	Aug 16 1930
20. Undertaker: Neville & Rugg	Address: Buhl Ida

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
No. (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louis J. Roubinek 90

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine Roubinek

6. DATE OF BIRTH (month, day and year) aug 12 - 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orford Iowa

PARENTS

10. NAME OF FATHER Joseph Roubinek
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bohemia
12. MAIDEN NAME OF MOTHER Dant Knaus
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bohemia

14. Informant C. N. Roubinek
(Address) Burke Idaho

15. Filed Aug 11, 1930 J. F. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1930, to Aug 8, 1930
that I last saw h.. alive on Aug 8, 1930
and that death occurred, on the date stated above, at 7:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. A. Monson, M. D.
Aug 11, 1930 (Address) Burke, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Ida.	8/11 1930
20. Undertaker L. J. Johnson	Address Burke Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED SEP 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71896

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 34
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Helen Caroline Berry 90

(a) Residence. No. 4 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of M. A. Berry

6. DATE OF BIRTH (month, day and year) Dec 22 -

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Buffalo N.Y.

PARENTS

10. NAME OF FATHER Frank D. Smith.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Nellie V. Potter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant M. A. Berry (Address) Buhl Idaho

15. Filed Aug 7, 1930 J. W. Wrigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 1st, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-31, 1930, to 8-1-, 1930
that I last saw her alive on 8-1-, 1930
and that death occurred, on the date stated above, at 3 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart

(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Exophthalmic Goitre
(duration) about 4 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis .....
(Signed) Ko. Jennings, M. D.
8-1-, 1930 (Address) Buhl Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cem.	Aug 3 1930
20. Undertaker L. E. Johnson	Address Buhl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M-1-19. RECEIVED AUG 18 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71807

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Valley

City of McCall, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Emmett Ward.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: 8 (Month) 21 (Day) 1929 (Year)

7. AGE: Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): McCall, Idaho

10. NAME OF Father: Guy Paul Ward

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Johanna Van Leeuwen

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy Paul Ward
(Address) McCall, Idaho.

15. Filed July 23 1930 Della Cain, Local Registrar

MEDICAL CERTIFICATE OF DEATH

1185

16. DATE OF DEATH: July (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11th 1930 to July 12th 1930, that I last saw him alive on July 11th 1930, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Bowel Obstruction

Bowel Obstruction

(Duration) ..... yrs. 3 mos. 3- ds.

Contributory (Secondary)

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Dr. W. S. Craft M. D.

(Address) McCall, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? Home
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71999

PLACE OF DEATH
County of Valley
City of McCall

Registration District No. 15
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Curl Percy Homer (Horner) 182

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Homer

6. DATE OF BIRTH (month, day and year)

7. AGE: 38 Years | Months: Aug | Days: 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Auto Machine Shop
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS

10. NAME OF FATHER: Wm Homer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Rene Jarman
(Address) Col. apt 210 Nampa Ida

15. Filed Sept. 11, 1930 Bertha Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Accidental drowning
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W D Robb Coroner, M. D.
, 19 (Address) Valley County Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa Idaho | Date of Burial 19

20. Undertaker: W D Robb | Address: Cascade Ida

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7199

Registration District No. 15
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Valley
City of McCall
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME Laura Houser (Horner)

(a) Residence. No. 403 5th Ave North St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of C P Houser

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	Feb	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Stanford
(State or country) Ill

PARENTS

10. NAME OF FATHER W B Jarman
11. BIRTHPLACE OF FATHER (city or town) Ill
(State or Country)
12. MAIDEN NAME OF MOTHER Emma Sawyer
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Rene Jarman
(Address) Cal apt. 218 Nampa Ida

15. Filed , 19 Stella Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Accidental drowning

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C S Bob Sawyer, M. D.
, 19 (Address) Valley County Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial 19
Nampa Idaho	
20. Undertaker C S Bob	Address Cascade

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 719[illegible]

Registration District No. 75
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH

County of Valley
City of McCall
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME A. L. Betts

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	Apr.	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER David Betts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind
12. MAIDEN NAME OF MOTHER Viola Fogle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Geo. Betts
(Address) R 3. Nampa Ida.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Accidental drowning

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A S Robb Coroner, M. D.
, 19 (Address) Valley County Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Nampa Ida	
20. Undertaker A S Robb	Address Cascade

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71901

PLACE OF DEATH
County of Valley
City of McCall

Registration District No. 15
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

82

2. FULL NAME Grace Betts

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of A. L. Betts

6. DATE OF BIRTH (month, day and year)

7. AGE 35 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) MO.

PARENTS
10. NAME OF FATHER — Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Geo. Betts
(Address) R 3 Nampa, Ida.

15. Filed , 19 Stella Cain, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4.30 P m.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dr U S Craft, M. D.
, 19 (Address)
A D Robb Coroner Valley Co

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Nampa | Date of Burial 19

20. Undertaker A D Robb | Address Cascade

RECEIVED SEP 11 1930

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of McCall

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. , St.)

File No. 71903

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sammer Wm Dee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1862 (Year)

7. AGE: 68 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Fox Farming

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Holton Kans

10. NAME OF FATHER: Chester Dee

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Elizabeth Blake

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bella Dee

(Address) McCall Ida

15. Filed Aug 5 1930 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 3 (Month) - (Day) 1930 (Year) 74a

17. I HEREBY CERTIFY, That I ~~attended~~ only saw deceased ~~from~~ after death ~~19 , to~~ on Aug 3 1930 that I last saw him alive on about Aug 1 1930, and that death occurred on the date stated above, at a M.

The CAUSE OF DEATH* was as follows:

apparently apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Heart disease of

(Duration) 3 yrs. mos. ds.

(Signed) Don S. Armstrong M. D.

19 (Address) McCall, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCall Idaho

DATE OF BURIAL: Aug 6th 1930

20. UNDERTAKER: A D Robb

ADDRESS: Cascade Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 9 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7193

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Washington

City of Midvale

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erasmus Jay Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 29 (Month) 1874 (Day) 1 (Year)

7. AGE: 63 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Noah H Harris

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Porter

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Reavis

(Address) Midvale, Idaho

15. Filed 9-5-30 1930

DR. E. T. WHITEMAN
CAMBRIDGE, IDAHO

Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

74a

16. DATE OF DEATH: Sept (Month) 2 (Day) 193[redacted]

17. I HEREBY CERTIFY, That I attended deceased from 9/1/30 191..., to 9/3/30. 191..., that I last saw her alive on 9/2/30 191..., and that death occured on the date stated above, at 7:30. P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Anuria.

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Arterio-sclerosis. Chronic nephritis.

..... (Duration) 10 Yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

19..... (Address) Cambridge, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale

DATE OF BURIAL: 9-6 1930

20. UNDERTAKER: J Affleburn

ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

71904

DO NOT WRITE IN THIS SPACE
State File No. 71904

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005 Local Registrar's No. 104

(No. 169)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Leighton Blaine Knox

(a) Residence. No. 1012 W. Jefferson, Boise Ida St.
(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 24 - 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Albany Oregon

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) U. W. Knox 1012 W. Jefferson, Boise

15. Filed 8-25-1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 21 (Month) (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Drowning - Suicide
No Inquest

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L. Evans, M. D.

9-10-30, 19 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill Cemetery — Date of Burial: 9-11-30 19

20. Undertaker: Paul L. Evans — Address: Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. .....

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 104
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John Doe

(a) Residence. No. Unknown St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	- -

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Paul L.Case Caldwell Idaho

15. Filed 8-25-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 1930 (Month) Unknown likely in (Day) , 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cause unknown. Removed from Snake river near Nyssa Oregon on Idaho side on Aug 22 1930. Body badly decomposed. Evidently in wate several weeks. (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) No inquest. No trace of identity.
.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....

(Signed) Paul L. Case, M.D. Coroner
August 25-30 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	8-23-30 19
20. Undertaker	**Address**
Paul L.Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

71905

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71905

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 81

112

PLACE OF DEATH
County of Ada
City of Boise
(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME REED, Albert W.

(a) Residence. No. 225 S. 4th St. Pocatello, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Helen C. Reed (Wife)

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	9	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Vermont
(State or country)

PARENTS

10. NAME OF FATHER corr
xx

11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)

12. MAIDEN NAME OF MOTHER
xx

13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant L. H. Beaman
(Address) U.S. Veterans' Bureau

15. Filed 9-17-1930 W. N. Rhodes Registrar
R.S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September (Month) 16 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1930, 19..., to Sept. 16, 1930, 19...
that I last saw him alive on Sept. 16, 1930, 19...
and that death occurred, on the date stated above, at 10.07 a.m.
The CAUSE OF DEATH* was as follows:
Shock following gastroenterostomy

(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Paralysis respiratory center
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept. 12, 1930
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) F. C. SMITH, Reg. Med. Officer, U.S.V.B., Boise, Ida.
Sept. 16, 1930, 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Ida	9-18-30 19
20. Undertaker: Shumaker & Beasley	Address: Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

71906

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71906

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 78
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MARKELL, Steven W.

(a) Residence. No. (Usual place of abode) St. Kellogg, Idaho (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Dorothy I. Markell (Wife)

6. DATE OF BIRTH (month, day and year) 6-23-1890

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER xx
11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx
12. MAIDEN NAME OF MOTHER xx
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L.H. Beaman
(Address) U.S. Veterans' Bureau

15. Filed 9-13, 1930 W.H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, 19..., to Sept. 12, 1930, that I last saw him alive on Sept. 12, 1930, 19... and that death occurred, on the date stated above, at 11.00 p.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of lung

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute fibrinous pericarditis.

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy

(Signed) F.C. Smith, M. D.
9-13-30, 19... (Address) U.S.V.B., Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane, Wash.	Sept. 17, 1930
20. Undertaker	Address
Zenhazen & Jaeter	Spokane, Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

71907

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71907

PLACE OF DEATH

County of Ada.
City of Boise Idaho.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 439
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Otto F. Steen.
(a) Residence. No. I4I7 North I7 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. I4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Steen.

6. DATE OF BIRTH (month, day and year) Jan. 2I I846.

7. AGE Years 84 Months 7 Days I2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Hardware Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Olso.
(State or country) Norway.

PARENTS
10. NAME OF FATHER Thorn Steen.
11. BIRTHPLACE OF FATHER (city or town) Norway.
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Norway.
(State or County)

14. Informant (Address) R. L. Steen
I406 North 6th Street Boise.

15. Filed 9-4, 1930 W. H. Rhodes R.S. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 3rd (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 8, 1930, to Sept 3, 1930
that I last saw him alive on Sept 3, 1930
and that death occurred, on the date stated above, at 8P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Alfred Budge Jr. M. D.
Sept 4, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Sept. 7 1930

20. Undertaker Summers & Krebs
Address Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

71908

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71908

PLACE OF DEATH
County of Ada.
City of

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 80
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74B

2. FULL NAME John Miller Thorn
(a) Residence No. 3 West of Boise St. Weiser Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha M Thorn.

6. DATE OF BIRTH (month, day and year) Dec. 21-1869

7. AGE Years 60 Months 7 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work U.S. Rural
(b) General nature of industry, business, or establishment in which employed (or employer) Mail Carrier
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spring Grove Illinois

PARENTS

10. NAME OF FATHER Adam Craig Thorn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Jane Isabelle Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) Martha M Thorn R.D. # 3. Weiser Idaho

15. Filed 9-15, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930 to Sept 13, 1930
that I last saw h..... alive on Sept 13, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Hodgkins Disease

(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Weiser Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Symptoms
(Signed) James L. Stewart, M. D.
9/15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Weiser Idaho Date of Burial Sept 15 1930

20. Undertaker Summers & Krebs Address Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 6 1930

71909

DO NOT WRITE IN THIS SPACE

State File No. 71909

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 66

98B

PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. Page Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ferdinand J. Haase

(a) Residence. No. ..... St. Trout Creek, Montana.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Haase

6. DATE OF BIRTH (month, day and year) November 22, 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	9	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Jason Haase

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Waskevitz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Nellie Haase

(Address) Trout Creek, Montana.

15. Filed Sept 13, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 12, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to Sept 12, 1930

that I last saw him alive on Sept 11, 1930

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm F. Tyler, M. D.

Sept 13, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitepine Cemetery, Mont	19
20. Undertaker L. G. MOON	Address SANDPOINT? IDA

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7191

Registered No.

1. PLACE OF DEATH.

Registration District No. 66

Primary Registration District No. 2145

County of Latah

City of Potlatch (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maude V. Morgareidge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept. (Month) 25 (Day) 1873 (Year)

7. AGE: 56 yrs. 11 mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gosport, Ind.

10. NAME OF FATHER: Joseph VanBuskirk

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Chrissie Crab

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W.F. Morgareidge

(Address) Potlatch, Ida.

15. Filed Sept. 12 1930 J.M. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH. 90

16. DATE OF DEATH: Sept, 9, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 — 1930, to Sept 9 — 1930 that I last saw her alive on Sept 8 — 1930 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Chronic Myocarditis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) F. Gibson M. D.

19..... (Address).....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow, Ida. DATE OF BURIAL: 9/14/30 191

20. UNDERTAKER: F.R. Short ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

7912

DO NOT WRITE IN THIS SPACE

State File No. 7912

Local Registrar's No.

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 3

Primary Registration District No. 1005

(No. 25 If death occurred in a hospital or institution, give its name instead instead of street and number.) 115

2. FULL NAME George A Bartlett

(a) Residence. No. 922 Dearborn St. 29

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 12 1866

7 AGE: Years 64 | Months 3 | Days 2 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Com. Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Woodstock Ill.

PARENTS

10 NAME OF FATHER: G. H. Bartlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs Geo Bartlett

(Address) 922 Dearborn Caldwell Ida

15 Filed 9-16-, 1930. John S. Meyer - Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 14 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____, that I last saw h____ alive on ____, 19____, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Judging from history of symptoms I judge he died from heart failure

death due to angina Pectoris

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Goodman Coroner, M. D.

9-15, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	9-18 1930
20. Undertaker C. J. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

71913

DO NOT WRITE IN THIS SPACE

State File No. 71913

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Jerome

City of Jerome

2. FULL NAME Wm Manley Ritchey

(a) Residence. No. St. Boise, Ida.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): March 31, 1895

7. AGE — Years: 35 | Months: 5 | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Aviator. C. Pilot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Farmington Iowa

PARENTS

10. NAME OF FATHER: Wm. G. Ritchey

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ina B. Scott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): West Virg.

14. Informant: Mrs. W. M. Ritchey

(Address): Nampa, Ida.

15. Filed 9/29, 1930 Chas. F. Zeller Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:

Killed in Air Plane Crash. Body burned when Plane burned up

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Nampa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J R Wiley Coroner

9-29, 1930, (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Nampa Idaho	
20. Undertaker D. L. Herrman	Address Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 11 1920

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.....

Registration District No.....

Primary Registration District No.....

Local Registrar's No.....

PLACE OF DEATH

County of .....

City of Boise

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Manley Ritchey

(a) Residence. No. Boise Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 31-1895

7. AGE Years	Months	Days	If LESS than 1 day,
35			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Air Plane Pilot
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Farmington Wash

PARENTS

10. NAME OF FATHER Wm G. Ritchey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo.

12. MAIDEN NAME OF MOTHER Ina B. Scott

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) West Va

14. Informant Mrs W. M. Ritchey
(Address) Nampa, Ida.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nampa Ida	10-1 1920
20. Undertaker	**Address**
F. T. Patterson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

PLACE OF DEATH

County of Ada

City of Meridian

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

71914

DO NOT WRITE IN THIS SPACE

State File No. 71914

Registration District No. 11

Primary Registration District No. 2003

Local Registrar's No. 12

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Sarah Louderbaugh

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Orange Louderbaugh

6. DATE OF BIRTH (month, day and year) Sept 6th 1860

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	11	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maryetta Georgia

PARENTS

10. NAME OF FATHER Jeptha Harbin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Mary Bruce

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant O O Louderbaugh

(Address) Meridian Ida

15. Filed 9/3, 1930 T F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 2nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-30, 1930, to Sept 2, 1930

that I last saw her alive on Sept. 2, 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Brights

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) T F Neal, M. D.

9-3, 1930 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Meridian, Ida

Date of Burial 9-6 1930

20. Undertaker B. W. Robison

Address Meridian, Ida

RECEIVED SEP 18 19

71915

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71915

Registration District No. 8 6
Primary Registration District No. 1016
Local Registrar's No. 6

164

PLACE OF DEATH
County of Washington
City of Weiser

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles York

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Color	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Fannie York

6. DATE OF BIRTH (month, day and year) Dec 29. 1847

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	7	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) N. H.

PARENTS

10. NAME OF FATHER John York
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant Bert York
(Address) Weiser Idaho

15. Filed Aug 9th 1930 W. R. Hamilton Registrar
By L. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Aug. 8, 1930
that I last saw him alive on Aug 7, 1930
and that death occurred, on the date stated above, at 9 a m.
The CAUSE OF DEATH was as follows:

senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic myocarditis.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) F. A. Schmidt M. D.
8-9-, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Intelligent Cemetery	8-9-1930
20. Undertaker	**Address**
L. C. Northam	Weiser Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

PLACE OF DEATH RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71916

County of Ada
City of Boise
Registration District No. 5
Primary Registration District No. 2004
Local Registrar's No. 84

(No. U.S. Veterans Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME SMITH, Harold P.

(a) Residence. No. 1720 N. 19th St. St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Harold P. Smith (Wife)

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	9	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER xx
11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)
12. MAIDEN NAME OF MOTHER xx
13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant L.H. Beaman
(Address) U.S. Veterans Bureau, Boise, Idaho

15. Filed 9-23, 1930 W.T. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930, 19..., to Sept. 21, 1930 19...
that I last saw h im alive on Sept. 21, 1930, 19...
and that death occurred, on the date stated above, at 3.25 p. m.
The CAUSE OF DEATH* was as follows:
Hemorrhage

(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Banti's Disease
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) F.C. SMITH, Reg. Med. Off., M. D.
Sept. 22, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept. 23, 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Idaho

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED OCT 4 1930

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71917

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 86

(No. Ada County Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nathanial B. Daniels,

(a) Residence. No. Boise, Ida St.

(Usual place of abode.)

Length of residence in city or town where death occured 37 yrs. — mos. — ds. — How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Dec. 12, 1840

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
89	9	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER James Danials

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Sarah Hamond

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) M. C. Hull Boise Idaho

15. Filed 9-29-1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 27, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Sept 27, 1930

that I last saw alive on Sept 27, 1930

and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Myocarditis (Chronic)

(duration) yrs. 8 mos. 27 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Ada County

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Boynton, M. D.

Sept 29, 1930 (Address) Boise Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill cemetery — Date of Burial: (9/29/30 19

20. Undertaker: W. McBratney — Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71918

PLACE OF DEATH

County of Ada

City of —

Registration District No. 8

Primary Registration District No. 2004 Local Registrar's No. 85

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs. Erma E. Lane

(a) Residence. No. Eagle, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 3 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of O. O. Lane

6. DATE OF BIRTH (month, day and year) 5/29 — 1896

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
34	3	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER W. L. Case

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) O. O. Lane Eagle, Idaho.

15. Filed 9-24, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 20 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 20, 1930
that I last saw her alive on Sept 15, 1930
and that death occurred, on the date stated above, at a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis.

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab.
(Signed) Hewey T. Nokes M. D.
9-22-30, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 9-24-30, 19

20. Undertaker W. McBratney Address Boise Idaho.

should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71919

PLACE OF DEATH
County of Ada
City of near the Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 83
(No.) 62
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ernest Tennison Chorn
(a) Residence. No. 31 st. Street & Pennsylvania Ave
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 6 1912

7. AGE Years 18 Months 1 Days 7 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS
10. NAME OF FATHER Elmer Chorn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Annie Cameron
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Neb.

14. Informant (Address) Elmer Chorn

15. Filed 9-17, 1930 W. H. Pleasant Boise Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 12, 1930, to Sep 13, 1930
that I last saw him alive on Sep 12, 1930
and that death occurred, on the date stated above, at 6:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Status Lymphaticus and persistant large Thymus gland
(duration) Since Birth yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? At Birth
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) J. N. Bilaxan M. D.
Sep 15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetry
Date of Burial 9-15 1930

20. Undertaker Schreiber McCann
Address Boise Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED OCT 4 1930

John Board

DO NOT WRITE IN THIS SPACE

State File No. 71920

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 82

(No. Route 4 5 Boise Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Austin Roland Clark

(a) Residence. No. Route 4 5 Boise, Idaho St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Clark

6. DATE OF BIRTH (month, day and year) August, 25, 1870

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Susanna Steele

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) Mrs. A. R. Clark, Boise, Idaho

15. Filed 9-17 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1930 to Sept 12th, 1930
that I last saw him alive on Sept 12th, 1930
and that death occurred, on the date stated above, at 1230 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy - sudden death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Chronic Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Board M. D.

9/15/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9-17 1930

20. Undertaker W. McBratney Address Boise, Idho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED OCT 4 1930

PLACE OF DEATH

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71921

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 79

(No. 18 miles N. W. Boise)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Madison Barnett

(a) Residence. No. 18 miles N.W. Boise St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jennie Barnett

6. DATE OF BIRTH (month, day and year) April 13, 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	4	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Wallace Barnett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Brucilla Spickelmire

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant Mrs Charles Barnett (Address) Star Idaho

15. Filed 9-13 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 9, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1930 to Sept 9 1930 that I last saw him alive on Sept 9 1930 and that death occurred, on the date stated above, at 11 30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

9/11/30 (Signed) A. W. Mack, M. D.

(Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Ada County Cemetery	9/12/30 19
20. Undertaker W. McBratney	Address Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 71922

PLACE OF DEATH

County of Ada.

City of Boise.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004 Local Registrar's No. 77

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. **FULL NAME** Wilma Evelyn Bower.

(a) Residence. No. 10 Miles N. W. of Boise. St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W.

5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 6, 1930.

7. AGE Years — Months — Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ranch 8 miles N. W. of Boise.

PARENTS

10. NAME OF FATHER Herman Bower.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hillsboro, Ore.

12. MAIDEN NAME OF MOTHER Evelyn Beatty

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Twin Falls, Idaho.

14. Informant (Address) Herman Bower Boise Idaho R 3.

15. Filed 9-11, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 7, 1930

that I last saw her alive on Sept 7, 1930

and that death occurred, on the date stated above, at 10 30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Unknown

Probably Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. W. Hall M. D.

9/10, 1930 (Address) Star Idaho,

19. Place of Burial, Cremation or Removal Morris Hill Cemetery

Date of Burial 9-8-30 19

20. Undertaker W. McBrakey

Address Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Gearway

DO NOT WRITE IN THIS SPACE
State File No. 71923

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 76
(No. 8 Miles Southwest of Boise)
(If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Martha Jane Sutton
(a) Residence. No. 8 Miles Southwest of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Sutton

6. DATE OF BIRTH (month, day and year) March, 19, 1858

7. AGE Years 72 Months 5 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Jacksonville
(State or country) Ore

PARENTS
10. NAME OF FATHER Samuel South
11. BIRTHPLACE OF FATHER (city or town) Arkansas
(State or Country)
12. MAIDEN NAME OF MOTHER Rhoda Robertson
13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or County)

14. Informant (Address) Mrs. W.E. Wines Meridain, Idaho

15. Filed 9-4, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 4, 1930
that I last saw her alive on Sept 3, 1930
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
acute Gastro. Enteritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bad food
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? traveling in car
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? yes
(Signed) Chas. P. Gearway, M. D.
9/5/30, 19 (Address) Boise, Ida

19. Place of Burial, Cremation, or Removal Portland, Ore. Date of Burial 9-6 1930

20. Undertaker W. McBratney Boise, Address Idaho

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71924

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 4245
(No. Boise River-- Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

169

2. FULL NAME Louis John Dullenty

(a) Residence. No. ____ St. Wolf Point, Mont.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) Jan. 12, 1895

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
35	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lincoln
(State or country) Neb.

PARENTS

10. NAME OF FATHER John Dullenty

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Minnie Alice Walker

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Illinois

14. Informant Fred Dullenty
(Address) Wolf Point, Mont.

15. Filed 9-8 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ____, 19__, to ____, 19__
~~that I last saw him~~ alive on ____, 19__ ~~and that~~ death occurred, on the date stated above, at about 6:40 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Suicide. Drowned
himself in Boise River.

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) No. Ingest heed.
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? No. Date of ____
Was there an autopsy? No.
What test confirmed diagnosis? ____
(Signed) W. McBratney, Coroner
9/6/30, 19__ (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9/8/30 19

20. Undertaker W. McBratney
Address Boise, Ida.

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71925

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 244
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Darrell Ray Kiger

(a) Residence. No. 162 St. Hastings Neb.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 26, 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hastings
(State or country) Neb.

PARENTS

10. NAME OF FATHER Willie LeRoy Kiger
11. BIRTHPLACE OF FATHER (city or town) Paine County
(State or Country) Oklahoma
12. MAIDEN NAME OF MOTHER Mamie Hoggatt
13. BIRTHPLACE OF MOTHER (city or town) Paine County
(State or County) Oklahoma

14. Informant Mr. W. L. Kiger
(Address)

15. Filed 9-8, 1930 W.H.Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1930 to Sept 3rd, 1930
that I last saw him alive on Sept 3, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature] M. D.
9/5/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9/5/30 19
20. Undertaker W. McBratney Boise,	**Address** Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71926

PLACE OF DEATH
County of Ada.
City of Boise Idaho.
Registration District No. 2
Primary Registration District No. 1002.
Local Registrar's No. 243
(No. 14)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eliza, Rebecca Howell.

(a) Residence. No. 1214 Bannock st St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William Howell.

6. DATE OF BIRTH (month, day and year) Oct. 13-1859.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	II	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Odgen
(State or country) Utah.

PARENTS

10. NAME OF FATHER John Staker.
11. BIRTHPLACE OF FATHER (city or town) Canada.
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Anna Wiggins.
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Illinois.

14. Informant William Howell. 1214 Bannock st
(Address) Boise Idaho

15. Filed 9-8, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4-1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 5, 1930, to Death, 19
that I last saw h alive on August 5, 1930
and that death occurred, on the date stated above, at 5.50 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
just before death.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) L. J. West, M. D.
9-6, 1930 (Address) 413 Eastman Bldg.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Sept 8 1930
20. Undertaker Summers & Krebs
Address Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71927

PLACE OF DEATH

County of Ada
City of ~~Meridian~~ Boise

Registration District No. 2
Primary Registration District No. 1904
(No. St. Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 242

119

2. FULL NAME Frances Lee Hudson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 31, 1923

7. AGE Years 7 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Hosp. Ida

PARENTS

10. NAME OF FATHER Frank Hudson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Meridian Ida
12. MAIDEN NAME OF MOTHER Nettie Gilbert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Eagle Ida

14. Informant Mrs. Daisy Snyder
(Address) Meridian Idaho

15. Filed 9-8, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1930, to Sept. 5, 1930
that I last saw her alive on Sept 5, 1930
and that death occurred, on the date stated above, at 5:50 A.m.
The CAUSE OF DEATH* was as follows:
Colitis (Strepo Staph)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. F. Neal, M. D.
9-6, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Meridian Ida
Date of Burial: 9-7 1930

20. Undertaker: O. W. Robison
Address: Meridian Ida

Stone

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71928

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 241

(No. St. Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1600

2. FULL NAME Mrs. Addie Poland

(a) Residence. No. 1310 Alturas St.
(Usual place of abode.)

Length of residence in city or town where death occured. 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Everett Poland

6. DATE OF BIRTH (month, day and year) April 24, 1880.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	4	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Elevator Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Solomon Mosher

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant Percy Poland
(Address) Boise Ida.

15. Filed 9-8 19 30 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Ruptured appendix

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Sept August 30?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harold W. Stone M. D.

9/8/30 19..... (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9/8/30 19

20. Undertaker	Address
W. McBratney	Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71929

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 24
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gertrude E. Gibson

(a) Residence. No. ..... St. Burns Oregon
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Burg Gibson

6. DATE OF BIRTH (month, day and year) Aug 28-1909

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
21	0	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burns Oregon

PARENTS
10. NAME OF FATHER Isaac N. Hughet
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Calif.
12. MAIDEN NAME OF MOTHER Lillie Pfordt
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) Burg Gibson Burns Ore

15. Filed 9-6-30 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Sept 5, 1930, that I last saw her alive on Sept 5, 1930, and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rupture or Perforation of Urinary Bladder.
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Toxaemia
Peritonitis (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) F. M. Bryan Dr. M. D.
Sept 5, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Burns Oregon — Date of Burial Sept 8 1930
20. Undertaker Summers & Krebs — Address Boise Idaho

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Stone of Road

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71930

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 238
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME John Belk McLane
(a) Residence. No. 2614 Madison St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elisabeth McLane

6. DATE OF BIRTH (month, day and year) March, 16, 1898

7. AGE Years 32 Months 5 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) State Highway Garage
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ceresco Neb.

PARENTS
10. NAME OF FATHER John F. McLane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lincoln Neb.
12. MAIDEN NAME OF MOTHER Dora I. Belk
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ceresco Neb.

14. Informant (Address) Mrs. John F. McLane

15. Filed 9-3 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August, 29, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1930, to Aug 29, 1930
that I last saw him alive on Aug 29, 1930
and that death occurred, on the date stated above, at 10 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Suicidal caused by gun shot wound thru liver
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 21 '30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. V. Boack, M. D.
9/3/30, 19 (Address) Boise, Ida

19. Place of Burial, Cremation, or Removal Clendale, Cal. Date of Burial 9-3 1930
Address

20. Undertaker W. McBratney Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Budge

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71931

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 237

117

2. FULL NAME Lucetta Grace Holbrook
(a) Residence. No. Route # 1 Boise, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Holbrook

6. DATE OF BIRTH (month, day and year) Oct. 17, 1897

7. AGE Years 32 Months 10 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clearwater Idaho

PARENTS
10. NAME OF FATHER Washington J. Lytle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Joe Davis County Ill.
12. MAIDEN NAME OF MOTHER Mable Grace Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Joe Davis County, Ill

14. Informant (Address) Mrs. Lytle Frederick Stites, Idaho

15. Filed 9-3, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 2, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Sept 2, 1930
that I last saw her alive on Sept 2, 1930
and that death occurred, on the date stated above, at 9 40 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured appendix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 31
Was there an autopsy?
What test confirmed diagnosis? Surgical findings
(Signed) Alfred Budge Jr., M. D.
9/3/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Stites, Idaho
Date of Burial m 9/4/30 19

20. Undertaker W. McBratney Boise, Idaho
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71932

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 7
Primary Registration District No. 1004
Local Registrar's No. 236
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Harvey L. Walker

(a) Residence. No. Cascade, Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Ona Walker

6. DATE OF BIRTH (month, day and year): Oct., 9, 1866

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	10	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Not Known

14. Informant (Address): Ona Walker, Cascade, Idaho

15. Filed 9-3 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August, 28, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23, 1930 to Aug 29, 1930
that I last saw him alive on Aug 28, 1930
and that death occurred, on the date stated above, at 6 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(duration) 4 yrs. 4 mos. 7 ds.
CONTRIBUTORY (Secondary) Pulmonary Odema & Decompensation
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Valley County
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

8/28/30 (signed) J. H. Grafton, M. D.
19 (Address) Boise, Ida

19. Place of Burial, Cremation, or Removal: Cascade, Ida. Date of Burial: 8/31/30 19

20. Undertaker: W. McBratney Address: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

1

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71933

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 87

(No. U.S. Veterans Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME HATFIELD, Edward Douglas

(a) Residence. No. ..... St. Mapleton, Utah
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Dorothy Hatfield (Wife)

6. DATE OF BIRTH (month, day and year) June 18, 1893

7. AGE	Years	Months	Days	If LESS than 1 day,
	37	3	11	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Utah
(State or country)

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant L.H. Beaman

(Address) U.S. Veterans' Bureau, Boise, Idaho

15. Filed 9-30, 1930 W. W. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept. 18, 1930, 19..., to Sept. 29, 1930
that I last saw him alive on Sept. 28, 1930
and that death occurred, on the date stated above, at 4.35 a. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arterial hypertension and Chr. parenchymatous nephritis.

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F.C. SMITH, Reg. Med. Officer M. D.

Sept. 29, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
	Oct. 2, 1930

20. Undertaker	Address
Wheeler Mortuary Co.,	Springville, Utah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71934

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 258
(No. St. Lukes Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Edwin Herrington

(a) Residence. No. Boise, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs Merge Herrington

6. DATE OF BIRTH (month, day and year) 6-4-1862

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
68	3	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Apartment House
(b) General nature of industry, business, or establishment in which employed (or employer) Owner
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Louis, Mo

PARENTS

10. NAME OF FATHER Henry Herrington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Mary ? Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dont Know

14. Informant (Address) Mrs. Merge Herrington Boise, Idaho

15. Filed 9-24, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept, 24, 193 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 24, 1930
that I last saw h..... alive on Sept 23, 1930
and that death occurred, on the date stated above, at 3 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Ida
Did an operation precede death? Yes Date of 9/18/30
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) [illegible], M. D.
9-24-30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Portland, Ore. Date of Burial Sept 9-25 1930

20. Undertaker W. McBratney Address Boise Idaho

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71935

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 257
(No. St. Alphonsus Hos.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME David V. Breen
(a) Residence. No. St. Placerville
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Breen

6. DATE OF BIRTH (month, day and year) April 27 1873

7. AGE Years 57 Months 4 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmet, Mich.

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Irland
12. MAIDEN NAME OF MOTHER Elizabeth
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Irland

14. Informant (Address) Mary Breen Placerville Ida

15. Filed 9-24 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 2 (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to Sept 23 1930
that I last saw him alive on Sept 22 1930
and that death occurred, on the date stated above, at 5:50 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tuberculosis pulmonary

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) Chas V. Genovay, M. D.
Sept 24 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Placerville, Ida
Date of Burial 9-26 1930

20. Undertaker Schreiber & McCann
Address Boise, Ida

Genovay.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71936

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1104 Local Registrar's No. 256
(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Kate Flournoy Tage
(a) Residence. No. 516 Bannock St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 65 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Edgar Burrows Tage

6. DATE OF BIRTH (month, day and year) Feb. 18th – 1850

7. AGE Years 80 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Linneus Linn Co. Missouri

PARENTS
10. NAME OF FATHER Augustus N. Flournoy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Anne E. Holland
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Chesterfield Co. Va

14. Informant (Address) A F Tage Salmon, Ida

15. Filed 9-24, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 21 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18, 1930, to Sept 21, 1930
that I last saw her alive on Sept 20, 1930
and that death occurred, on the date stated above, at 4:30a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
General Carcinomatosis primary in the parotid gland left side. Senility
Carcinoma (duration) 2 yrs. mos.
CONTRIBUTORY (Secondary) Carcinoma
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis Physical Exam.
(Signed) Gerald T. Nokes M. D.
Sept 23, 1930 (Address) Boise Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 9/23 1930

20. Undertaker Schreiber & McCann
Address Boise, Ida

Note

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71937

RECEIVED OCT 4 1930

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 255
(No. St Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lawrence Lloyd Young.

(a) Residence. No. La Grande, Oregon. St. La Grande, Oregon.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 8.1927.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	4	15.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) La Grande Oregon.
(State or country)

PARENTS

10. NAME OF FATHER Lloyd Young.
11. BIRTHPLACE OF FATHER (city or town) Boise, Idaho.
(State or Country)
12. MAIDEN NAME OF MOTHER Carran Miller.
13. BIRTHPLACE OF MOTHER (city or town) Nebraska.
(State or County)

14. Informant Lloyd Young.
(Address) 503. Washington St. La Grande, Ore.

15. Filed 9-23 19.... W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930, to Sept 23, 1930
that I last saw him alive on Sept 22, 1930
and that death occurred, on the date stated above, at 2:15 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lymphosarcoma

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None

(Signed) Lucas V. Simmons M. D.
Sept 23, 1930 (Address) La Grande

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Sept. 24 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930
RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71938

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 254
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rudolph R. Kuss
(a) Residence. No. St. Murphy, Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie M. Kuss

6. DATE OF BIRTH (month, day and year) Jan. 17-1865

7. AGE Years 65 Months 8 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Postmaster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Carrie M. Kuss Murphy Ida

15. Filed 9-20, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 19, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Sept 18, 1930
that I last saw him alive on 8:30 PM 9/18/, 1930
and that death occurred, on the date stated above, at 6:45 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestional Obstruction
(Volvulous ilium)

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Shock from Operation
(duration) yrs. mos. 12/24 hrs.

18. Where was disease contracted if not at place of death? Murphy Ida
Did an operation precede death? Yes Date of 9/18/30
Was there an autopsy? no
What test confirmed diagnosis? Usual
(Signed) C. S. Allen, M. D.
9/20, 1930 (Address) 218 Eastman Bldg

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 9/21 1930

20. Undertaker Schreiber & McCann
Address Boise, I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71939

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 253
(No. St Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME James Remmington Bartlett
(a) Residence. No. 117 E Bannock St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 28, 1909

7. AGE 21 Years | Months 2 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Service Station Attendant
(b) General nature of industry, business, or establishment in which employed (or employer) Automotive Service
(c) Name of employer Frank Maitland

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS

10. NAME OF FATHER George S. Bartlett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kendallville, Indiana
12. MAIDEN NAME OF MOTHER Jenny Kinney
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wisconsin

14. Informant (Address) F. A. Bartlett 117 E Bannock, Boise, Idaho

15. Filed 9-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 12, 1930
that I last saw him alive on Sept 12, 1930
and that death occurred, on the date stated above, at 2:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. A. Forlsch, M. D.
Sept 17, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery | Date of Burial 9-16 1930

20. Undertaker Schreiber McCann | Address Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71941

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes)
Local Registrar's No. 252

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** Gertie Emery

(a) Residence. No. ∨ St. Buhl Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Wht	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph D Emery

6. DATE OF BIRTH (month, day and year) Jan. 4-1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	8	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Concordia Kans.

PARENTS

10. NAME OF FATHER Frank Jardoe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wisconsin

14. Informant (Address) J D Emery Buhl, Ida

15. Filed 9-18, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-14-, 1930, to 9-17-, 1930
that I last saw her alive on 9-17-30, 19
and that death occurred, on the date stated above, at 3 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Metastatic Carcinoma
Brain & Lung (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? Buhl, Idaho
Did an operation precede death? Yes Date of 1926 & 1928
Was there an autopsy? no
What test confirmed diagnosis? Pathology
(Signed) Ernest E. Lamb M. D.
9/18, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Buhl, Idaho — Date of Burial 9/18 1930

20. Undertaker: Schreiber & Williams — Address: Rose, I

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Transcript

DO NOT WRITE IN THIS SPACE
State File No. 71941

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 251
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Sally Lou Banning

(a) Residence. No. ____ St. Independence, Mo.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ____

6. DATE OF BIRTH (month, day and year) February, 18, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs, or ____ min.
	6	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Independence
(State or country) Missouri

PARENTS

10. NAME OF FATHER George Banning
11. BIRTHPLACE OF FATHER (city or town) ____
(State or Country) Kansas
12. MAIDEN NAME OF MOTHER Alpha Opal Roe
13. BIRTHPLACE OF MOTHER (city or town) Granby
(State or County) Missouri

14. Informant Mr. L. E. Roe
(Address) Slater, Missouri

15. Filed 9-17 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 15, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Not attended, 19____
that I last saw her alive on ____, 19____
and that death occurred, on the date stated above, at 6:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Double lobar pneumonia

reported (duration) 0 yrs. 0 mos. 1 ds.
CONTRIBUTORY (Secondary) Improper feeding—
(duration) about yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? Enroute from Missouri
Did an operation precede death? ____ Date of ____
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy findings

(Signed) Harmon M. Freiman M. D.
9/16/30, 19____ (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9-17 1930
20. Undertaker	**Address**
W. McBratney	Boise, Idaho

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71942

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 250

65a

2. FULL NAME Sybil J. Johnson
(a) Residence. No. Kuna Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 16 - 1930

7. AGE Years — Months 6 Days 26 If LESS than 1 day, ... hrs, or ..... min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Kuna
(State or country) Ida

PARENTS
10. NAME OF FATHER Henry Johnson
11. BIRTHPLACE OF FATHER (city or town) Sweden
(State or Country)
12. MAIDEN NAME OF MOTHER Sybil Gale
13. BIRTHPLACE OF MOTHER (city or town) Utah
(State or County)

14. Informant (Address) Henry P. Schaeffer Nampa

15. Filed 9-15, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Sept. 12, 1930
that I last saw her alive on Sept. 12, 1930
and that death occurred, on the date stated above, at 1 30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Symphatic Leukemia

possibly (duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary) Lobar pneumonia
probable (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? no Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Blood findings.
(Signed) Harmon A. Freeman M. D.
Sept. 13, 1930 (Address) Boise.

19. Place of Burial, Cremation, or Removal Kuna Cemetery
Date of Burial 9/14 1930

20. Undertaker Schreiber & McCann
Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71943

PLACE OF DEATH

County of Boise
City of Ada

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 249
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Orr

(a) Residence. No. ..... St. Glenns Ferry, IdA,
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 7th. 1905

7. AGE Years 25 Months 8 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) MO,

PARENTS

10. NAME OF FATHER Frank Hutchcraft
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Lucie Nolan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant (Address) Gilbert Zacher, Mountain Home, Ida.

15. Filed 9-15, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 13/30, 19..... (Month) (Day) (Year)

17. I HEREBY ~~CERTIFY~~, That I attended deceased from Sept 5, 1930 to Sept 12, 1930
that I last saw h..... alive on Sept 12, 1930
and that death occurred, on the date stated above, at 6'20 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

General Septicaemia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Self Induced Miscarriage

(duration) ..... yrs. ..... mos. 12 ds.

18. Where was disease contracted if not at place of death King Hill Ida
Did an operation precede death? Yes Date of Sept 8-30
Was there an autopsy? No
What test confirmed diagnosis? Sands & old placenta
(Signed) L. F. West [illegible] D.
9/13, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Glenns Ferry, Ida. Date of Burial 9/15 1930

20. Undertaker Zacher Funeral Home Address Mountain Home, Ida

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71944

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St Lukes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 248

1113

2. FULL NAME Clara Josephine Fagerstedt
(a) Residence. No. 411 West Liberty St. Weiser Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: K C Fagerstedt Dec 12 1891

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 38, Months 8, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Obert, Neb.

PARENTS

10. NAME OF FATHER: L J Winger
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Betsy Knutson
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Suldbrandsdal Norway

14. Informant (Address): John Fagerstedt

15. Filed 9-12, 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 3 1930 to September 11 1930
that I last saw her alive on September 11 1930
and that death occurred, on the date stated above, at 4:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Perforating Duodenal Ulcer

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cholecystitis
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of September 5
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Harold W Stone M. D.
9/12, 1930 (Address) 317 Eastman Bldg Boise

19. Place of Burial, Cremation, or Removal: Weiser, Ida
Date of Burial: Shipment 9-12 1930

20. Undertaker: Schreiber + McCann
Address: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71945

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 247

2. FULL NAME Mrs Frances Bowers.
(a) Residence. No. Horseshoe Bend, Ida St. Horseshoe Bend, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. — yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert R. Bowers.

6. DATE OF BIRTH (month, day and year) Dec. 25, 1900

7. AGE Years 29 Months 8 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Horseshoe Bend, Ida

PARENTS

10. NAME OF FATHER Edwin F. Stone.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Anna Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Georgia

14. Informant (Address) Robt R. Bowers Horseshoe Bend, Ida.

15. Filed 9-9, 1930 W. H. R[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept, 7 — 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/7, 1930 to 9/7, 1930
that I last saw her alive on 9/7, 1930
and that death occurred, on the date stated above, at 9:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto accident. Shock & Hemorrhage from crushed leg
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) Ralph Faith, M. D.
Sept 8, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Horseshoe Bend. Date of Burial 9-9 1930

20. Undertaker W McBrotney Address Boise Idaho

Stone

STATE OF IDAHO

RECEIVED OCT 4 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71946

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 246

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1004a

2. FULL NAME Ellen Josephine Dial

(a) Residence. No. Route # 4 Boise, Idaho St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 32 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John Dial

6. DATE OF BIRTH (month, day and year) March, 31, 1845

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
85	5	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Rogers

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Emma Whipple

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Mrs. Josie Dial Boise, Idaho

15. Filed 9-8 1930 W H Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 7, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to ____, 19__

that I last saw her alive on ____, 19__

and that death occurred, on the date stated above, at ____ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Fracture of neck of left femur

(duration) ____ yrs. ____ mos. 30 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harold W Stone M. D.

9/8/30, 19__ (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	8-9 193

20. Undertaker W. McBratney Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71947

PLACE OF DEATH
County of Ada.
City of ~~Boise~~ Idaho.
Meridian R.F.D. 2.
Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 11
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Lawrence Pender.

(a) Residence. No. 11 Miles South West of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Amy Florence Pender.

6. DATE OF BIRTH (month, day and year) April-12-1870.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	4	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Yorkshire.
(State or country) England.

PARENTS

10. NAME OF FATHER Matthew Pender.
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) England.
12. MAIDEN NAME OF MOTHER unknown.
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) England.

14. Informant Reginald Pender.
(Address) Meridian Idaho.

15. Filed 8/31, 1930 W. F. Mead Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 30-1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-28, 1930, to 8-30, 1930
that I last saw him alive on 8-30, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bright's.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. F. Mead, M. D.
8-30, 1930 (Address) Meridian

19. Place of Burial, Cremation, or Removal: Meridian Idaho.
Date of Burial: Sept. 2-1930

20. Undertaker: Summers & Krebs
Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71948

PLACE OF DEATH
County of Ada
City of Meridian

Registration District No. 11
Primary Registration District No. 2003
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 13

74B

2. FULL NAME Julius A. Kunkle

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, ~~or~~ Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Kunkle

6. DATE OF BIRTH (month, day and year) June 10, 1860

7. AGE Years 70 Months 2 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer, Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dont Know Germany

PARENTS
10. NAME OF FATHER Andrew Kunkle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know Germany
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know Germany

14. Informant Harry Kunkle
(Address) Corral Ida

15. Filed 9/3, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 2nd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-25, 1930, to 7-28, 1930
that I last saw him alive on 7-28-30, 19..
and that death occurred, on the date stated above, at 2:50 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Laboratory
(Signed) O. F. Swindell, M. D.
7-28, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal Corral, Idaho. Date of Burial 9-3 1930

20. Undertaker B. W. Robison Address Meridian Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71949

Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 14

119

PLACE OF DEATH

County of Ada
City of Meridian
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John Wesley Hudson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of

6. DATE OF BIRTH (month, day and year) May 10, 1849

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	81	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer. Retired 15 years
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Unknown
(State or country) Missouri

PARENTS

10. NAME OF FATHER W. Hudson
11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country) Missouri
12. MAIDEN NAME OF MOTHER Martha Irwin
13. BIRTHPLACE OF MOTHER (city or town) Indiana
(State or Country)

14. Informant Mrs. Daisy Snyder
(Address) Meridian Ada

15. Filed 9/18, 1930 A F Neal
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 18th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/29, 1930, to 9/18, 1930
that I last saw him alive on 9-17, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

colitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Senility
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A. F. Neal, M. D.
9/19, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or ~~Removal~~	Date of Burial
Meridian Idaho	9-20 1930
20. Undertaker B. W. Robison	Address Meridian Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71950

PLACE OF DEATH
County of Ada
City of Meridian Idaho
Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 15
(No.) 119
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nannetta Estelle Burwell

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs, or min.
3	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS
10. NAME OF FATHER George E. Burwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Elizabeth J. Best
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montana

14. Informant Mrs Geo E. Burwell
(Address) Meridian Idaho.

15. Filed 9/22, 1930 H F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-21, 1930, to 9-21, 1930
that I last saw her alive on 9-21, 1930
and that death occurred, on the date stated above, at 1230 m.
The CAUSE OF DEATH* was as follows:
Colitis
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H F Neal M. D.
9-21, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	Sept 23 1930
20. Undertaker W. S. Maker	Address Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71951

PLACE OF DEATH
County of Ada
City of Meridian
Registration District No. 11
Primary Registration District No. 2003
Local Registrar's No. 16
(No.) 114
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura K Nielsen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of R. M. Nielsen

6. DATE OF BIRTH (month, day and year) Nov. 10, 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	10	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Unknown (State or country) Denmark

PARENTS

10. NAME OF FATHER Andrew Olsen
11. BIRTHPLACE OF FATHER (city or town) Unknown (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Ann Sorensen
13. BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country) Denmark

14. Informant Anna Nielsen
(Address) Meridian Idaho Rt 3

15. Filed 9/26, 1930 A F Mead Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 25, 1930
that I last saw her alive on Sept 24 1930
and that death occurred, on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency

(duration) yrs. mos. 12 ds.
CONTRIBUTORY (Secondary) General debility
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C C Applegate M. D.
9-27-, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian, Ida.	9-28 1930
20. Undertaker B. W. Robison	Address Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED SEP 18 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No. 2160
File No. 71952
Registered No. 13

1. PLACE OF DEATH

County of Bannock
City of Arimo
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zelma Ruth Gunter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED ~~Single~~ (Write the word.)

6. DATE OF BIRTH April (Month) 30 (Day) 1930 (Year)

7. AGE Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James Gunter

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Zelma Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Gunter

(Address) Arimo, Idaho

15. Filed Sept 1 1930 Mary C. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-5-1930, to July-21-1930 that I last saw her alive on July-15-1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pertussis and broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) Pertussis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) H. J. Hartigan, M. D.

7-22 1930 (Address) Downey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~ Arimo, Ida — **DATE OF BURIAL** July 22 1930

20. UNDERTAKER None — **ADDRESS**

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 84

DO NOT WRITE IN THIS SPACE
State File No. 71953
Local Registrar's No. 192

PLACE OF DEATH
County of Bannock
City of Grace
Registration District No.
Primary Registration District No. 216
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orrid Connel Smith

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 2nd 1930

7 AGE: Years 0 | Months 6 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Grace
(State or country) Idaho

PARENTS

10 NAME OF FATHER William Coleman Smith

11 BIRTHPLACE OF FATHER (city or town) Grace
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Coetta Hale

13 BIRTHPLACE OF MOTHER (city or town) Grace
(State or country) Ida

14 Informant Mother
(Address)

15 Filed Oct 1, 1930 Mrs. G. G. Fitz, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 18th 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930 to Sept 18, 1930
that I last saw him alive on Sept 18, 1930
and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:
Paratyphoid Fever
(duration) — yrs. — mos. 6 ds.
CONTRIBUTORY (Secondary) Measles
(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? Blackfoot Ida
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Joseph C. Otte M. D.
9-18-, 1930 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Grace Ida — Date of Burial: 9-20- 1930

20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71954

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Grace — Primary Registration District No. 2161

Local Registrar's No. 191

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

188e

2. FULL NAME Everett Peck

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clive Knowles Peck

6 DATE OF BIRTH (month, day and year): Mar. 1, 1889

7 AGE: Years 41 | Months 6 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Lewiston Utah

PARENTS
10 NAME OF FATHER: Arthur V. Peck
11 BIRTHPLACE OF FATHER (city or town) (State or country): Salt Lake City, U.
12 MAIDEN NAME OF MOTHER: Penina Glazier Peck
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Tennessee

14 Informant: Father
(Address): Burley Idaho

15 Filed Oct-1, 1930 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 7 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Not at all, 19 , to , 19 , that I last saw him alive on Sept 5, 1930, and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH* was as follows:
Auto Accident.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph E. Otte M. D.
9-9- 1930 (Address) Grace Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Grace Idaho — Date of Burial: 9-9- 1930

20. Undertaker — Address

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71955

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161 Local Registrar's No. 5904

(No. 857 South Main St. Poca., Ida.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. **FULL NAME** Maurine Ellett

(a) Residence. No. 857 South Main Street. St.

(Usual place of abode.)

Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 8, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Ida.

PARENTS

10. NAME OF FATHER M. D. Ellett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fremont, Utah.

12. MAIDEN NAME OF MOTHER Marie Livengston

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Blackfoot, Idaho.

14. Informant M. D. Ellett (Address) Pocatello, Ida.

15. Filed 9/22/30. 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 21, (Day) 1930. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Sept 21, 1930

that I last saw her alive on Sept 21, 1930

and that death occurred, on the date stated above, at 10 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Swillen, M. D.

9/22/30. 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: McCammon Cemetery McCammon, Idaho. Date of Burial: 9/23/30. 19

20. Undertaker: Arthur W. Hall Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 14 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No. ..... St.)

File No. 71956

Registered No. 5903

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hilma Elvira Elledge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1893 (Year)

7. AGE: 38 Yrs. 8 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Chris J. Halston

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christine Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wheeler W. Elledge

(Address) Lava Hot Springs

15. Filed 9-23 1930

[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

111a

16. DATE OF DEATH: Sept (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1930, to Sept 19 1930 that I last saw her alive on Sept 19 1930, and that death occurred on the date stated above, at 2:25 A.M.

The CAUSE OF DEATH* was as follows: Perforating Gastric ulcers

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) None Known

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

9-19 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State 15 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Central, Idaho

DATE OF BURIAL: Sept 2, 1930

20. UNDERTAKER: McHan Undt Co.

ADDRESS: Pocatello

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71957

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5902
(No. 641 South Main Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Burnett McGarvey

(a) Residence. No. 641 South Main St. Poca., Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 42 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Clara Clark

6. DATE OF BIRTH (month, day and year) December 11, 1868.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Peace Officer
(b) General nature of industry, business, or establishment in which employed (or employer) Constable
(c) Name of employer Bannock County, Idaho.

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Mrs. Burnett McGarvey
(Address) 641 South Main St. Pocatello, Ida.

15. Filed 9/20/30. 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 18, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930 to Sept 18, 1930
that I last saw him alive on Sept 18, 1930
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Carcinomatosis

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) William F. Howard, M. D.
9/20/30. 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery Pocatello, Idaho.	9/21/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Roberts

DO NOT WRITE IN THIS SPACE
State File No. 71958

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
(No. Gen Hospital)
Local Registrar's No. 5901
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James A. Wilson

(a) Residence. No. 140 So Lincoln St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Coach Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. A. Westover
(Address) 140 So Lincoln

15. Filed 9-18, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-7, 1930, to 9-16, 1930
that I last saw h[illegible] alive on 9-16, 1930
and that death occurred, on the date stated above, at 8.30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach
and colon
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of 9/15/30
Was there an autopsy? [illegible]
What test confirmed diagnosis? [illegible]
(Signed) [illegible] M. D.
9/18, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	9-20th 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

Dve

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71959

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5900
(No. Lynn Brothers Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Anna May Mitchell
(a) Residence. No. 335 North Sixth Ave. Poca., Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 20, 1923.

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
6	10	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER J. E. Mitchell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Anna Laura Haitt
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant J. E. Mitchell
(Address) 335 North Sixth Ave. Poca., Ida.

15. Filed 9/18/30, 19... J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 16, (Day) 1930. (Year) 19...

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930 to Sept 16, 1930
that I last saw her alive on Sept 16, 1930
and that death occurred, on the date stated above, at 1:15 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) —
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? phy Examination
(Signed) J. H. Lynn, M. D.
9/17/30., 19... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Idaho Falls Cemetery, Idaho Falls, Idaho.
Date of Burial: 9/19/30. 19

20. Undertaker: Arthur W. Hall
Address: Pocatello

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71960

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5899
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lena Milly
(a) Residence. No. Pocatello, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Miller

6. DATE OF BIRTH (month, day and year) March 1, 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	6	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Frank Yeager
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Catherine Myers
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant Mrs. E. F. Riswold
(Address) Pocatello, Idaho

15. Filed 9-15, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22, 1930 to Sept 14, 1930
that I last saw h[illegible] alive on 9-13-, 1930
and that death occurred, on the date stated above, at 9:50 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) 2nd stroke
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
9-12, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal: Idaho Falls Idaho — Date of Burial: Sept. 16 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71961

PLACE OF DEATH

County of Bannock

City of Pocatello

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161 Local Registrar's No. 5898

(No. Poc. Gen. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Helen Elaine Atkins

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 28, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	6	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Ida.

PARENTS

10. NAME OF FATHER James C. Atkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Margaret Kattel

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) James C. Atkins Tyhee, Pocatello Idaho

15. Filed Sept 16 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 14, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 14, 1930 that I last saw h.. alive on Sept 14, 1930 and that death occurred, on the date stated above, at 1:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

acute infectious diarrhea

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) D. E. Ray M. D.

9-16, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello, Ida — Date of Burial: Sept 16 1930

20. Undertaker: McHan Undt Co — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71962

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 24

Primary Registration District No. 2161

Local Registrar's No. 5899

(No. 1553 East Fremont St. Poca., Ida.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Nestor Henry Davis

(a) Residence. No. 1553 East Fremont St. St.

(Usual place of abode.)

Length of residence in city or town where death occured 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

14

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Francis Alice Pettil

6. DATE OF BIRTH (month, day and year) August 30, 1854.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	0	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10. NAME OF FATHER Joseph Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Lydia Esterbrook

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mass.

14. Informant (Address) Walton Davis Pocatello, Idaho.

15. Filed 9/16/30. 19.... Registrar. J P Gormley

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 14, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1930 to Sept 14 1930 that I last saw h[illegible] alive on 8-28 1930 and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage gastric

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) D C Ray, M. D.
9/15/30. 19.... (Address) Pocatello, Id

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. — Date of Burial: 9/16/30. 19

20. Undertaker: Arthur W. Hall — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71963

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2761
Local Registrar's No. 5898
(No. 527 E. Johnson)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Maria C. Giordano
(a) Residence. No. 527 E. Johnson St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Sam Giordano
6. DATE OF BIRTH (month, day and year)
7. AGE: 59 Years | 10 Months | 3 Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Italy
PARENTS
10. NAME OF FATHER: Joseph Dutto
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Frances Indaco
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy
14. Informant: Sam Giordano
(Address): Pocatello Idaho
15. Filed 9-18, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 10, 1930, that I last saw h alive on Sept 10, 1930, and that death occurred, on the date stated above, at 10.30 p m.
The CAUSE OF DEATH* was as follows: Chronic Nephritis
(duration) Yrs. yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. 1 mos. 5 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) William D. Howard M. D.
9/11, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Sept 14 1930
20. Undertaker: Schumacher & Reudy — Address: Pocatello

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71964

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5897

48 B

PLACE OF DEATH

County of Bannock
City of Pocatello
(No. County Infirmary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Hutchinson

(a) Residence. No. County Infirmary St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown

7. AGE: Years: About 70 | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Schumacher & Beasley
(Address) Pocatello Idaho

15. Filed 9-9, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-1, 1928, to 9-9, 1930
that I last saw him alive on 9-8, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows: Myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Ac. Art. Rheumatism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. H. Young, M. D.
9-9, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	9-9 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71965

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5914
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

24

2. **FULL NAME** Virgina Ann Francis

(a) Residence. No. 349 North Buchanan St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 15 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
1	3		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10. NAME OF FATHER John L. Francis
11. BIRTHPLACE OF FATHER (city or town) Marabell
(State or Country) Calif.
12. MAIDEN NAME OF MOTHER Elda K. Green
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Utah

14. Informant John L. Francis
(Address)

15. Filed 10-7, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 6 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept. 2, 1930, to Oct 6, 1930
that I last saw her alive on Oct 6, 1930
and that death occurred, on the date stated above, at ...m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Brain Abscess

(duration) ...yrs. ...mos. 6 ds.
CONTRIBUTORY (Secondary) Acute Mastoiditis
(duration) ...yrs. 1 mos. ...ds.

18. Where was disease contracted if not at place of death? none
Did an operation precede death? yes Date of Sept. 29, 1930
Was there an autopsy? yes
What test confirmed diagnosis? Symptoms & Cerebral fluid
(Signed) C. W. Pond, M. D.
Oct. 7, 1930 (Address) Rand Bldg.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Ogden Utah	
20. Undertaker	Address
H. L. McHan	Paca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Roberts

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71966

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 126 Roosevelt)
Local Registrar's No. 5913

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Carline Haskin

(a) Residence. No. 1126 Roosevelt St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 26 - 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	3	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10. NAME OF FATHER J. H. Blaylock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Clinton Haskin
(Address) Pocatello

15. Filed 10-4, 1930 J. H. Hammond Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/15, 1930, to 10/3, 1930, that I last saw h alive on 10/11, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.
10/4, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	10/5th 1930
20. Undertaker	Address
Schumacher & Brooks	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71967

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216 Local Registrar's No. 5912
(No. 1612)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** James Burton Langton
(a) Residence. No. Rural Route #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 24-1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~Born to-day~~		6.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho.

PARENTS.
10. NAME OF FATHER Ralph Langton
11. BIRTHPLACE OF FATHER (city or town) Ontario.
(State or Country) Canada.
12. MAIDEN NAME OF MOTHER Ida May Robinson
13. BIRTHPLACE OF MOTHER (city or town) Regent
(State or County) Man. Toba.

14. Informant Mr. Ralph Langton
(Address)

15. Filed 9-30, 1930 J R Young. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Sept 30, 1930
that I last saw h[illegible] alive on Sept 30, 1930
and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia meningitis
Rapid birth.
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D C Ray, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Mt. View Cemetery — Date of Burial Oct. 1 1930
20. Undertaker H. L. McGan — Address Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71965

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5911
(No. Residence 4 Miles West of City)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louisa J. Woodland

(a) Residence. No. Four Miles West of Poca., City St.
(Usual place of abode.)
Length of residence in city or town where death occured. 16 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wife of Henry S. Woodland

6. DATE OF BIRTH (month, day and year) April 9, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	5	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Franklin, Idaho.

PARENTS

10. NAME OF FATHER Andrew Morrison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Mary Ann Smart
13. BIRTHPLACE OF MOTHER (city or town) (State or County) France

14. Informant Henry S. Woodland
(Address) Pocatello, Idaho.

15. Filed 9/30/30., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 28, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 28, 1930, that I last saw h.... alive on Sept 27, 1930, and that death occurred, on the date stated above, at 10 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) O. [illegible], M. D.
9/29/30., 19..... (Address) Poca., Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho. — Date of Burial: 9/30/30. 19

20. Undertaker Arthur W. Hall — Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71970

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
(No. 547 N 4th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5907

78

2. FULL NAME Jennie Gates
(a) Residence. No. 547 N 4th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Louis Gates

6. DATE OF BIRTH (month, day and year) June 21—1866

7. AGE Years 64 Months 3 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ithay

PARENTS
10. NAME OF FATHER Mike Rossi
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ithay
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ithay

14. Informant Mike Gates
(Address) Pocatello Ida

15. Filed 9-27, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/1, 1930, to 9/25, 1930
that I last saw h— alive on Sept 1, 1930
and that death occurred, on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) A. P. Groom, M. D.
9/25, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt Vieu
Date of Burial 9-28 1930

20. Undertaker Schumacher & Beasley
Address Pocatello

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 71971

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5906
(No. 651 West Whitman St. Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** William Hancock

(a) Residence. No. 651 West Whitman St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Emerata Bingham

6. DATE OF BIRTH (month, day and year) July 17, 1857.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	2	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payson, Utah.

PARENTS

10. NAME OF FATHER Charles Hancock

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Cloean Rawson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois

14. Informant Leo Hancock
(Address) Pocatello, Idaho.

15. Filed 9/24/30., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 22, (Day) 1930. (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from
March 10, 1930, to Sept 22, 1930
that I last saw h[illegible] alive on 9-22, 1930
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Esophagus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) D C Ray, M. D.
9/23/30., 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Blackfoot Cemetery, Blackfoot, Idaho. — Date of Burial: 9/25/30. 19....

20. Undertaker: Arthur W. Hall — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71972

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5905
(No. 406 S 5th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mary Batten.

(a) Residence. No. 406 S 5th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 27th 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	II	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Chas. Cochrane.
(Address) Pocatello Ida

15. Filed 4-22, 1930 J. W. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21 (Month) (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Sept 21, 1930, that I last saw h[illegible] alive on Sept 20, 1930, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) Few yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. Few mos. ds.

18. Where was disease contracted if not at place of death? South Dakota
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) William A. Howard M.D.
Sept 27, 1930 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	9/24 19

20. Undertaker Schumacher & Beasley Inc Address Pocatello
S Chumache

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71973

PLACE OF DEATH

County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

92

2. FULL NAME Amie C. Campo

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Peter E. Campo

6. DATE OF BIRTH (month, day and year) June 8, 1874

7. AGE 5 Years 56 Months 3 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ranch
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carson City, Nev.

PARENTS
10. NAME OF FATHER John P. Meder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Gussie ? (Meder)
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Peter E. Campo
(Address) St. Maries, Ida

15. Filed Oct 7, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h— alive on ....., 19.....
and that death occurred, on the date stated above, at 5.35 A m.
The CAUSE OF DEATH* was as follows:
Embolism
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. G. Espe, Coroner, M. D.
9/28, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal St Maries — Date of Burial Sept 30 1930

20. Undertaker Geo E Mitchell — Address St Maries

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 16 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah — Registration District No. 32

City of St. Maries — Primary Registration District No. 2 of 9

(No. ..... St.)

File No. 7197

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Cain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Section laborer

(b) General nature of industry, business, or establishment in which employed (or employer)... Railroad

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Robins

(Address) St. Maries, Ida

15. Filed Oct 7 1930 — Walter Boberg, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1930 (Year) — 9 A.M.

17. I HEREBY CERTIFY, That I attended deceased from June 13th 1930, to Sept 20th 1930, that I last saw him alive on Sept 20th 1930, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Bronchitis — Purulent, non-tuberculous, Chronic

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) Arthritis Chronic

(Duration 1 yr. ..... mos. ..... ds.

(Signed) C. A. Robins M. D.

9/20 1930 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 3 mos. 7 days. In the State.....yrs. 5 mos.....days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Lotus, Idaho.

19. PLACE OF BURIAL OR REMOVAL: St. Maries, Ida — DATE OF BURIAL: 9-22 1930

20. UNDERTAKER: Lee E. Mitchell — ADDRESS: St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71975

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2029

Local Registrar's No. 34

(No. 578)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Beatrice Nelson

(a) Residence. No. 141 - 13th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Peter A. Nelson

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Own home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mpls. Minn

PARENTS

10. NAME OF FATHER Olaf Benson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Hanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Peter A. Nelson
(Address) 141 - 13th

15. Filed Oct. 1st, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-4, 1930, to 9-16, 1930
that I last saw her alive on 9/16, 1930
and that death occurred, on the date stated above, at 8:20 a. m.
The CAUSE OF DEATH* was as follows:
Pernicious anaemia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?
(Signed) G. E. Esp, M. D.
9/16, 1930 (Address) St. Maries Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spokane Wash	Sept 18 1930
20. Undertaker	Address
Osmeraga	Spokane Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71976

PLACE OF DEATH
County of Bonneville
City of Springfield

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 9

(No. 74a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erastus nelson wells

(a) Residence. No. ..... St. Springfield Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ mary Wells

6. DATE OF BIRTH (month, day and year) Aug 11 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	1	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Willard - Utah
(State or country)

PARENTS

10. NAME OF FATHER Erastus Nelson Wells,
11. BIRTHPLACE OF FATHER (city or town) Penn.
(State or Country)
12. MAIDEN NAME OF MOTHER Nancy Malinda Whittaker
13. BIRTHPLACE OF MOTHER (city or town) Penn
(State or Country)

14. Informant H. N. Wells
(Address) Springfield Ida

15. Filed Sept 29, 1930 Mamie Kinnon
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 29, 1930
that I last saw h.im alive on Sept 28, 1930
and that death occurred, on the date stated above, at 11 A - m.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Mamie Kinnon, M. D.
9-29, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Springfield Ida	Oct 2 1930
20. Undertaker Friends	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71977

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No. 116
Primary Registration District No. 2195
Local Registrar's No. 5

(No.) 98B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ben Henry McQueen

(a) Residence. No. Aberdeen, Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 28, 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	7	23	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Tazewell Co.
(State or country) Illinois

PARENTS

10. NAME OF FATHER William Henry McQueen
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Virginia
12. MAIDEN NAME OF MOTHER Rachella Davis
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Kentucky

14. Informant Davis Smith McQueen
(Address)

15. Filed 9/22, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 20, 1930
that I last saw him alive on Sept. 20, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical
(Signed) , M. D.
Sept. 20, 1930 (Address) Aberdeen, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen, Ida	9/22 1930
20. Undertaker	Address
A. W. Davis	American Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED OCT 8 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 71978
Local Registrar's No. 138

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glen LaVerle McBride

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Peter C. McBride

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Olive Leona Talbot

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... RD #5
(Address) P C McBride Blackfoot

15. Filed Sept. 29 1930 Mrs Walter E. Pate
Local Registrar

MEDICAL CERTIFICATE OF DEATH 161a

16. DATE OF DEATH: Sept (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1930, to Sept 29 1930 that I last saw him alive on Sept 29 1930 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Premature birth
(Duration) ..... yrs. 7th mos. ..... ds.
Contributory (Secondary) Premature detachment of Placenta
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W W Beck M. D.
9/29 1930 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: L. C. Cem. Blackfoot Ida
DATE OF BURIAL: Sept 30 1930

20. UNDERTAKER: Mrs Bert Hofer
ADDRESS: Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71979

PLACE OF DEATH

County of BINGHAM

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 137

(No. South Idaho Insane Asylum)

(If death occurred in a hospital or institution, give its name instead of street and number.)

76

2. FULL NAME JAMES LUNNY

(a) Residence. No. ..... St. Salmon
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 40 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of (Unknown - no record)

6. DATE OF BIRTH (month, day and year) unknown

7. AGE 70 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ---

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ---

14. Informant Thomas Carson, Att.
(Address) Blackfoot, Ida.

15. Filed Sept 29, 1930 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 28th 1930 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15th 1930, 19.., to Sept 28th 1930, 19..

that I last saw h..... alive on ....., 19..

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ——

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.

Sept 28 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Asylum Cem | Date of Burial Sept 29 1930

20. Undertaker Marion Clark | Address

MARGIN RESERVED FOR BINDING

...E PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...SE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... ...mportant. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71980

PLACE OF DEATH
County of Bingham
City of Firth

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 136

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

121

2. FULL NAME Robert Nelson Brewington
(a) Residence. No. Firth Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Clio Brewington

6. DATE OF BIRTH (month, day and year): Nov 8-1868

7. AGE: Years 61, Months 10, Days 19. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Isabelle Mo

PARENTS
10. NAME OF FATHER: William W. Brewington
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Rachel Bruce
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs Clio Brewington
(Address) Firth Ida
Sept 30, 1930 Mrs Hattie E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 27 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1929, to Sept 27, 1930
that I last saw him alive on Sept 26, 1930
and that death occurred, on the date stated above, at 6.30 A.m.
The CAUSE OF DEATH* was as follows:
Sarcoma of liver
(duration) 1 yrs. 6 mos. ds.
CONTRIBUTORY (Secondary): Myo Carditis
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) F. J. Robert, M. D.
Sept 27, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal: Idaho Falls Ida. Date of Burial: Sept 30 1930

20. Undertaker: J. F. McHan Address: Idaho Falls Ida.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7198 1

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 191
Primary Registration District No. 2194
Local Registrar's No. 135
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74

2. FULL NAME Louise E. Elliott

(a) Residence. No. ..... St. Rupert, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 33 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of (unknown no record)

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
92			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10. NAME OF FATHER Ogloie French

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xxxxxxxxxx

12. MAIDEN NAME OF MOTHER Ellis Ogloie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Minnie Hayes-Attendant
(Address) Blackfoot, Ida.

15. Filed Sept 13, 1930 Mrs Valeria E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1930 to Sept 13 1930
that I last saw her alive on Sept 13 1930
and that death occurred, on the date stated above, at 11:50A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Age

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Geo. Williams, M. D.
Sept 13 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida.	Sept. 16 1930
20. Undertaker	Address
D. E. Johnson	Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71982

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 134

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Lydia Brown Evans

(a) Residence. No. Blackfoot, Ida. Thomas Rt. #2 St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Evans

6. DATE OF BIRTH (month, day and year) Aug. 26. 1875

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	0	22	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Homer Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Hannah E. Wolf

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York.

14. Informant John H. Evans
(Address) Blackfoot, Rt. 2

15. Filed Sept 20, 1930 Mrs Nature E. Cabrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930, to Sept 18, 1930 that I last saw her alive on Sept 17, 1930 and that death occurred, on the date stated above, at 12:25 p. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage of Right side

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) J. O. Humphries, M. D.

Sept 20, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverside-Thomas Cem.

Date of Burial: 9-21-30 19

20. Undertaker: Modern Mortuary, Blackfoot, Ida.

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71983

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 133

90

2. FULL NAME Theresa Horne Bailey
(a) Residence. No. McDonaldville St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George R. Bailey

6. DATE OF BIRTH (month, day and year): June 13 1888

7. AGE: Years 42 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Salt Lake Utah

PARENTS
10. NAME OF FATHER: Richard S. Horne
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Mary A. Gillies
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Provo Utah

14. Informant: Geo. R. Bailey
(Address): Blackfoot Idaho

15. Filed Sept 8, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1928, to Sept 5, 1930
that I last saw her alive on Sept 6, 1930
and that death occurred, on the date stated above, at 3:30 A.m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) J. O. Humphries, M. D.
9-8, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation, or Removal~~ Burial: Groveland Cemetery
Date of Burial: 9/8 1930

20. Undertaker: E. T. Peck
Address: Blackfoot.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71984

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 12
Primary Registration District No. 2192
(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 132

2. FULL NAME Hans Peterson
(a) Residence. No. Blackfoot, R. F. D. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Make	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sarah Peterson

6. DATE OF BIRTH (month, day and year) May 4, 1860

7. AGE	Years	Months	Days	If LESS than 1 day,
	70	3	29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Hans Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Virgina Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Joe Peterson
(Address) Blackfoot, Ida.

15. Filed Sept 4, 1930 Mrs Helen E Eaton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 29, 1930 to Sept 3, 1930
that I last saw h— alive on Sept 3, 1930
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) J. O. Hampton, M. D.
Sept 4, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~	Date of Burial
Riverside-Thomas Cem.	9-7-30 19
20. Undertaker	Address
Modern Mortuary, Blackfoot.	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71985

PLACE OF DEATH
County of Blaine
City of Gannett

Registration District No. 57
Primary Registration District No. 2022

Local Registrar's No. 29

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ella Martin Allred

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Earl Allred

6. DATE OF BIRTH (month, day and year) Feb 12 - 1908

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Silver City Utah

PARENTS

10. NAME OF FATHER Martin Kiplinger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ella Kiplinger

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Ortella Jackson (mother)
(Address) Gannett Idaho

15. Filed 9-30, 1930 P. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

Fox

16. DATE OF DEATH Sept 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/20 1930, to 9-26, 1930
that I last saw her alive on 9-26, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis -
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted — if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. Fox, M. D.
9/26, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue - Ida	Sept 28 1930
20. Undertaker	Address
Harris & Amos	Hailey - Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71986

Registration District No. 57
Primary Registration District No. 2022
Local Registrar's No. 28

PLACE OF DEATH
County of Blaine
City of Gannett

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ellen Foster

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) Feb 26 1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	6	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Jos Ashton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Cunningham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Hilda Riley (Daughter)
(Address) 303 West Spruce Butte Mont

15. Filed 9-30, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: No Physician

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City Utah	19
20. Undertaker	Address
Harris & Sons	Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71987

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 27

117

2. FULL NAME Grover Franklin Gillihan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) April 24-1913

7. AGE Years 17 Months 4 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gannett Idaho

PARENTS

10. NAME OF FATHER George Gillihan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Pearl Chapman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Geo Gillihan
(Address) Gannett Idaho

15. Filed 9-30, 1930 R. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-28, 1930, to 9-4, 1930
that I last saw him alive on 9-4, 1930
and that death occurred, on the date stated above, at 11:30 P.m.
The CAUSE OF DEATH* was as follows:
Peritonites following ruptured appendix
..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 8-29-
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Robert H. Wright M. D.
9/4, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Picabo, Ida. Date of Burial Sept 6 1930

20. Undertaker Harris & Amos Address Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71988

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

2. FULL NAME James A Fletcher

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6. DATE OF BIRTH (month, day and year): May 26 - 1864

7. AGE: Years 6[illegible] Months 15 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS

10. NAME OF FATHER: X
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER: X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant: S. A. Bourgeois
(Address) Hailey Idaho

15. Filed 9-30, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1930, to Aug 3, 1930
that I last saw him alive on Aug 3, 1930
and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
8/4, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho — Date of Burial: Aug 6th 1930

20. Undertaker: Harris & Amos — Address: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71989

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Ponderay)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 70

28B

2. FULL NAME Mrs Maria Turner

(a) Residence. No. Ponderay St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 7 1845

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	0	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Asa Burnham
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant Mrs C M Sales
(Address) Ponderay

15. Filed Sept. 24, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/23, 1930, to 9/23, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4:30 P m.
The CAUSE OF DEATH* was as follows:
Chr N Myocarditis
Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Clinical.
(Signed) R B Ross M. D.
Sept. 24, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery
Date of Burial: 9/25 1930

20. Undertaker: Turnbull Co
Address: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71990

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 69

(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10 da

2. FULL NAME Vyron Chaffins

(a) Residence. No. 320 S Boyer St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Myrtle Chaffins

6. DATE OF BIRTH (month, day and year): Oct 23 1896

7. AGE: Years 34 | Months 11 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Railway clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): South Dakota

PARENTS

10. NAME OF FATHER: Mark Chaffins

11. BIRTHPLACE OF FATHER (city or town) (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Cornelia Morrison

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn

14. Informant: Mrs Mark Chaffins
(Address) Coeur d'alene

15. Filed Sept. 25, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/20, 1930, to 9/24, 1930 that I last saw him alive on 9/24, 1930 and that death occurred, on the date stated above, at 8:45A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. S. Ross M. D.

9/24, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery | Date of Burial: 9/26 1930

20. Undertaker: Turnbull Co | Address: Sandpoint

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71991

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 6

57

2. FULL NAME Merance La Fond

(a) Residence. No. 215 Cedar Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mitchell La Fond

6. DATE OF BIRTH (month, day and year) Sept. 17, 1847

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Montreal
(State or country) Canada

PARENTS

10. NAME OF FATHER Bruley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J. M. La Fond
(Address) Sandpoint, Idaho.

15. Filed Sept. 18, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 17th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21, 1930, to Sept 17, 1930
that I last saw her alive on Sept 16 1930
and that death occurred, on the date stated above, at 6 15 A. m.

The CAUSE OF DEATH* was as follows:
Diabetis

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Schlerosis
(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Chemical
(Signed) Wm F. Tyler, M. D.
Sept. 18, 1930. (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	9/19/30 19
20. Undertaker	**Address**
L.G.Moon	Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71992

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

114

2. FULL NAME Philip LeRoy Litrenta

(a) Residence. No. 901 Fifth Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 12, 1927.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER Thomas A. Litrenta

11. BIRTHPLACE OF FATHER (city or town) Vancouver
(State or Country) B.C. Canada

12. MAIDEN NAME OF MOTHER Gladys Reece

13. BIRTHPLACE OF MOTHER (city or town) Sprague
(State or Country) Washington

14. Informant Mrs. Gladys Litrenta
(Address) Sandpoint, Idaho.

15. Filed Sept. 17, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 15th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1930, to Sept. 13, 1930
that I last saw him alive on Sept. 13, 1930
and that death occurred, on the date stated above, at 2:17a. m.
The CAUSE OF DEATH* was as follows:
Dysentery and enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Floyd E. Wendle, M. D.
Sept. 17, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Sept. 17 1930

20. Undertaker	Address
L. G. Moon	Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71993

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 65

(No. Sandpoint Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Samuel Jason Hyatt

(a) Residence. No. ..... St. Cabinet, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Jane Hyatt

6. DATE OF BIRTH (month, day and year): January 29, 1863

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	7	6	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): Quartz

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Asheville N. C.

PARENTS

10. NAME OF FATHER: Jason Hyatt

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Asheville N. C.

12. MAIDEN NAME OF MOTHER: Julia Capps

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Asheville N. C.

14. Informant: Mrs. Myrtle Peterson
(Address): Clark Fork, Idaho

15. Filed Sept. 8, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 5, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ for many years, 19 to Sept 5, 1930 that I last saw him alive on Sept ~~30~~ 5, 1930 and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows: Chronic Parenchymatous nephritis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident with dislocation right kidney followed by pyelitis about 1924 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. P. Stackhouse, M. D.

9-6-, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lakeview Cemetery — Date of Burial: Sept. 8 1930

20. Undertaker: Moon Mortuary — Address: Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 6 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 71994

County of Bonner Registration District No. 85

City of Priest River Primary Registration District No. 2185

(No. .....)

Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Josephine Maccarato

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 32 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael Maccarato

6 DATE OF BIRTH (month, day and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 72			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Grimaldi Italy

PARENTS

10 NAME OF FATHER Dominic Pate

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Gallo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Henry M. Maccarato

(Address) Priest River, Ida

15 Filed Sept 26, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. (Month) 25 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1930, to Sept 24, 1930, that I last saw her alive on Sept. 24, 1930, and that death occurred, on the date stated above, at 2:05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Findings

(Signed) Harold C. Jones, M. D.

Sept 25, 1930 (Address) Priest River

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Sept 26 1930

20. Undertaker Address

Moon Mortuary Priest River

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71995

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2100
Local Registrar's No. 142
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Peggy Marie Kearney
(a) Residence. No. 100a St. Iona, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23 1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iona, Ida.

PARENTS
10. NAME OF FATHER Fred Kearney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wilford Ida.
12. MAIDEN NAME OF MOTHER Bertha Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nebraska

14. Informant (Address) Fred Kearney Iona, Ida.

15. Filed Oct 23, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1930, to Sept 20, 1930
that I last saw him alive on Sept 20, 1930
and that death occurred, on the date stated above, at 1:15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. mos. 30 ds.

18. Where was disease contracted if not at place of death? Iona
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [illegible], M. D.
Sept 24, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Annis Ida — Date of Burial: Sept. 23 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71996

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 143

179

2. FULL NAME James Lunn Staples
(a) Residence. No. ..... St. Brigham City Ut.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Etta Staples

6. DATE OF BIRTH (month, day and year) April 29, 1860

7. AGE Years 70 Months 4 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lehi, Utah

PARENTS
10. NAME OF FATHER George Staples
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ruth Rapley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mass.

14. Informant (Address) Levi Staples Shelley Rt #1

15. Filed Sept 19, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 18, 1930
that I last saw him alive on Sept 17, 1930
and that death occurred, on the date stated above, at 6-45 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Crushing injury Chest, (Horse jumped on him)
..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H. Ray Hatch M. D.
Sept 19 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Elsinore, Utah
Date of Burial Sept 21 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71997

PLACE OF DEATH

County of Bonneville. Registration District No.
City of Idaho Falls. Primary Registration District No. Local Registrar's No. 144

(No. I. F. L. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

149

2. FULL NAME Myrtle M Gourley.

(a) Residence. No. 128 - 15 St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: wm Gourley.

6. DATE OF BIRTH (month, day and year): January 18-1894

7. AGE — Years: 36. Months: 8 Days: 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER: James Everett.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah
12. MAIDEN NAME OF MOTHER: Mary J. Masseray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Franklin Idaho

14. Informant: wm Gourley
(Address): Idaho Falls Ida

15. Filed Sept 20, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h[illegible] alive on Sept. ..., 19...
and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(duration) ... yrs. ... mos. 1 hr ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of Sept 18-30
Was there an autopsy? ...
What test confirmed diagnosis? Laboratory

(Signed) [illegible], M. D.
..., 19... (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	9/21 1930.

20. Undertaker: W. F. McFarland Address: Idaho Falls Idaho

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 71998

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170
(No. Idaho Falls L. D. S. Hosp.)
Local Registrar's No. 16

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann (Homer) Boram.

(a) Residence. No. 47 St. Rigby Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F. M.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word.): Widowed.

5a. If married, widowed, or divorced (or) WIFE of: Alfred Boram.

6. DATE OF BIRTH (month, day and year): December 9, 1854

7. AGE: Years 75 | Months 9 | Days 1 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: General Merchandiser.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10. NAME OF FATHER: Russell King Homer.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Eliza Williamson.

13. BIRTHPLACE OF MOTHER (city or town) (State or County): Michigan.

14. Informant (Address): R. K. Homer. Rigby, Idaho.

15. Filed Sept 22, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 10, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1929 to Sept 10, 1930
that I last saw her alive on Sept 10, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Right breast.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept 13, 1929
Was there an autopsy? no
What test confirmed diagnosis? Laboratory

(Signed) W. Ray Hatch, M. D.
Sept 12, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Clarkston, Utah — Date of Burial: 9/14/30 19

20. Undertaker: [signature] — Address: Rigby

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72001

Local Registrar's No. 167

PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No.

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

119

2. FULL NAME Dennis Kent Ashlimans

(a) Residence. No. 412 Lomax St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
—	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho

PARENTS

10 NAME OF FATHER E. E. Ashlimans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Logan, Utah

12 MAIDEN NAME OF MOTHER Alta Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Franklin, Utah

14 Informant E. E. Ashlimans

(Address) Idaho Falls Idaho

15 Filed ....., 19.... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 24 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 22nd, 1930, to Aug 24, 1930, that I last saw him alive on Aug 24, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilocolitis

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) H. W. Bendetson M. D.

8-24, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL. or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Logan Utah — Date of Burial: Aug 26 1930

20. Undertaker: V. F. McHam — Address: Idaho Falls Ida

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72002

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 93
Primary Registration District No. 215-0
(No. L. U. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 168

126

2. FULL NAME Virginia Recendez
(a) Residence. No. 379 Eagle Rock St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1, 1926

7. AGE: Years 3, Months 8, Days, If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Butte, Montana

PARENTS
10. NAME OF FATHER: Silbestre Recendez
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Baparoso, Mexico
12. MAIDEN NAME OF MOTHER: Juana Rojas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mexico

14. Informant: Silbestre Recendez
(Address) Idaho Falls, Idaho

15. Filed Sept, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30, 1930, to Aug 31, 1930
that I last saw her alive on Aug 31, 19..
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Gen Peritonitis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Ruptured Appendicitis
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? yes Date of Aug 30
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) [signature], M. D.
8/31, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho
Date of Burial: Sept 2 1930

20. Undertaker: Jack A. Ward
Address: Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REGISTERED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72003

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bonneville Registration District No. 23

City of Idaho Falls Primary Registration District No. 2430 Local Registrar's No. 169

(No. Lincoln Ida)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Daniel Gonzales. 1000

(a) Residence. No. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Mexican

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 18-1929

7 AGE — Years: 1 | Months: 8 | Days: 13. | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho Falls Ida.

PARENTS

10 NAME OF FATHER: Jususe Gonzales

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mexico

12 MAIDEN NAME OF MOTHER: Trinidad Valdagez

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mexico

14 Informant: Jususe Gonzales.
(Address) Idaho Falls Ida.

15 Filed 9/x, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept. (Month) 1 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1930 to Sept. 1, 1930
that I last saw h[illegible] alive on aug. 30, 1930
and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harry L. Hellman M. D.

9/x, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Lincoln Ida — Date of Burial: 9/2 1930

20. Undertaker: V. F. McHan — Address: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 1 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72004

PLACE OF DEATH
County of Bonneville. Registration District No. 23
City of Idaho Falls Primary Registration District No. 2-1-2-5
Local Registrar's No. 170

(No. 2) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha Schuldt. 90

(a) Residence. No. 351 - 13th St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Carl Schuldt.

6. DATE OF BIRTH (month, day and year): Dec 29-1867.

7. AGE: Years 62 | Months 7 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: Henry Pieper
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Denk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Carl Schuldt.
(Address): Idaho Falls. Ida

15. Filed Sept, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1927, to aug 7, 1930
that I last saw her alive on aug 7 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Rheumatism

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H. D. Spencer, M. D.
Sept, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Holstein Iowa — Date of Burial: 9/3 1930

20. Undertaker: V. F. McHan — Address: Idaho Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72005

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 171

47B

2. FULL NAME Bessie Hix

(a) Residence. No. ..... St. Rigby Rt #2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. C. Hix

6. DATE OF BIRTH (month, day and year) July 27, 1889

7. AGE	Years	Months	Days	If LESS than 1 day,
	41	1	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Price, Utah

PARENTS

10. NAME OF FATHER Frank Helm
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mary Louisa Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake County, Utah

14. Informant Mr. J. C. Hix
(Address) Rigby Route #2

15. Filed Sept 17, 1930 C. Edmund Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to Sept 2, 1930
that I last saw h[illegible] alive on Sept 2, 1930
and that death occurred, on the date stated above, at 10 m. m.
The CAUSE OF DEATH* was as follows:
myocarditis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pyosalpinx Ruptured
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of July 31-30
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. D. Lemon, M. D.
Sept 4, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grant, Idaho	Sept 4 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72006

PLACE OF DEATH
County of Bonniville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140 Local Registrar's No. 172
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME James Gideon Oram
(a) Residence. No. Blackfoot, Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Muir Oram

6. DATE OF BIRTH (month, day and year)

7. AGE Years 77 Months 5 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R. R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Henry Oram
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Sarah Berry
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) Mrs. C. A. Hungerford Idaho Falls, Idaho

15. Filed Sept. 4, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 4 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2, 1930, to Sept. 4, 1930
that I last saw him alive on Sept. 4, 1930
and that death occurred, on the date stated above, at 11-45 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute enterocolitis.

(duration) yrs. mos. 7-10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical symptoms
(Signed) [signature], M. D.
Sept. 4, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal Blackfoot, Ida. Date of Burial Sept. 8 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72007

PLACE OF DEATH
County of Bonneville
City of Milo

CERTIFICATE OF DEATH
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 173
(No. 101 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Hyrum Bates.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~XXXXXXXXX~~ Jane Bates.

6. DATE OF BIRTH (month, day and year) Oct. 27, 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS

10. NAME OF FATHER John Bates.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Hannah Dracket.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) Est of V Bates. Rigby, R. #2

15. Filed Sept 4, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Sept. 2, 1930, to ....., 19....
that I last saw h[illegible] alive on Sept. 2, 1930.
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(duration) ....yrs. ....mos. 5 ds.
CONTRIBUTORY (Secondary) Senility
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) W. A. West, M. D.
9/6, 1930. (Address) Rigby Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	9/7/30 19

20. Undertaker C. B. Eckersell Address Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72008

Local Registrar's No. 174

160

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2170
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Mack

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 5, 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			2	11 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida.

PARENTS

10. NAME OF FATHER Gerald Mack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shenendoah, Iowa
12. MAIDEN NAME OF MOTHER Grace V. Hackworth
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lynchburg Va.

14. Informant Gerald Mack
(Address) 451 - H. St. Idaho Falls.

15. Filed Sept 9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1930, to Sept 8, 1930
that I last saw h[im] alive on Sept 8, 1930
and that death occurred, on the date stated above, at 9. A. m.
The CAUSE OF DEATH* was as follows:

Internal Hemorrhage

(duration) ..... yrs. ..... mos. 6 hrs

CONTRIBUTORY (Secondary) Icterus Neonatorum

(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs

(Signed) [signature], M. D.
Sept 9, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls	Sept. 9 193
20. Undertaker Jack A. Wood	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72009

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-0
Local Registrar's No. 174-
205-B

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isaac David Cooper

(a) Residence No. ..... St. Idaho Falls Rt. #1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Rosetta Rebecca Cooper

6. DATE OF BIRTH (month, day and year): Mar. 7 1853

7. AGE: Years 77, Months 5, Days 29. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): American Fork Utah

PARENTS

10. NAME OF FATHER: Isaac Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Nanci Lance
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs. P. M. Frandsen
(Address) Idaho Falls Rt. 1

15. Filed Sept 9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6:55 P m.
The CAUSE OF DEATH* was as follows:
Unknown - No medical
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
Sept 9, 1930 (Address) Sept 9/30 [signature]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Iona Ida. Date of Burial: Sept. 14 1930

20. Undertaker: Jack A. Wood Address: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72010

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2170
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 176

2. FULL NAME James Albert Cloward

(a) Residence. No. ..... St. Iona, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 31 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Maria Cloward

6. DATE OF BIRTH (month, day and year) Nov. 19, 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Black Smith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo Utah

PARENTS

10. NAME OF FATHER James Cloward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jackson Co. Missouri
12. MAIDEN NAME OF MOTHER Mary Ann Brown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) United States

14. Informant Maria Cloward
(Address) Iona Ida

15. Filed Oct 7, 1930 C. E. Simmons Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 6, 1930
that I last saw he alive on Sept 6, 1930
and that death occurred, on the date stated above, at 5:45 P m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) 1 yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Bronchitis leg
(duration) ... yrs. ... mos. 3 ds.

18. Where was disease contracted if not at place of death? Iona, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. E. Clews, M. D.
..., 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Ida.	Sept. 10 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72011

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 1 V 8

Local Registrar's No. 177

(No. L. D. S. Hosp.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Christian Peter Christensen.

(a) Residence. No. ..... St. Rigby, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E.

6. DATE OF BIRTH (month, day and year) Sept 21 1879

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	7	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark.

PARENTS

10. NAME OF FATHER: Christian M. Christensen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: Anna Erickson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark.

14. Informant: Mrs. Mary E. Christensen
(Address) Rigby, Idaho.

15. Filed Oct 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 3, 1930, to May 8, 1930 that I last saw him alive on May 8, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: following operation for peritonitis and ileus (acute appendicitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of May 4, 1930

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) [signature], M. D.

May 9, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rigby, Idaho

Date of Burial: 5/10/30 19

20. Undertaker: [signature] Address: Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED OCT 16 1930

DO NOT WRITE IN THIS SPACE
State File No. 72012

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 17
(No. 161a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Infant - Waters

(a) Residence. No. Idaho Falls, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 12/30

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
				2

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Jay Waters

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Pearl Butler

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant Mrs Jay Waters
(Address) Idaho Falls, Idaho

15. Filed Sept. 15, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1930, to Sept. 12/30, 19.....
that I last saw him alive on Sept. 12/30, 19.....
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature - 6 - 7 Months.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) [signature], M. D.
Sept. 15, 1930 (Address) Idaho Falls, Ida.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Ida. Date of Burial: Oct. 17 1930

20. Undertaker: None Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 1 0 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72014

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2140
Local Registrar's No. 180
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Frank Veeher
(a) Residence. No. ..... St. Roberts, Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Not Known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) (Not Known) 1874

7. AGE Years 56 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS
10. NAME OF FATHER "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) L. D. S. Hospital Idaho Falls

15. Filed ....., 19.... ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 11 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9th, 1930 to Sept 11, 1930
that I last saw him alive on Sept 10, 1930
and that death occurred, on the date stated above, at 2:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bilateral Lobar Pneumonia.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) A. R. Sedgwick, M. D.
Sept 15, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida
Date of Burial Sept. 13 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72015

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. .....
Primary Registration District No. .....
(No. L D S Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 141

119

2. **FULL NAME** Bobby Pete Raty

(a) Residence. No. ..... St. Iona, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3, 1930

7. AGE Years | Months 7 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Ida.

PARENTS

10. NAME OF FATHER Horace Raty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plain City Utah
12. MAIDEN NAME OF MOTHER Olive Frandsen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iona, Ida.

14. Informant (Address) Horace Raty Iona Ida.

15. Filed ....., 19.....
..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept 10, 1930
that I last saw him alive on Sept 10, 1930
and that death occurred, on the date stated above, at 1 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute entero-colitis

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) A Ray Hatch, M. D.
Sept 15, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Iona, Ida. | Date of Burial: Sept. 14 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72016

County of Bonneville
City of Idaho Falls, Idaho

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 349

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118a

2. FULL NAME Walter P. Olson

(a) Residence. No. St. Anthony Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~XXXXXXX~~ Alice Olson

6. DATE OF BIRTH (month, day and year) May 11-1872

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	4	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Danmark

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Danmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Danmark

14. Informant Irving Olson
(Address) St. Anthony, Idaho.

15. Filed Sept. 17, 1930 W. W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Sept 15, 1930, to only, 19—
that I last saw him alive on Sept 15, 1930
and that death occurred, on the date stated above, at 2 p m.
The CAUSE OF DEATH* was as follows: Strangulated hernia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Sept. 15 1930
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) T. A. Ellison, M. D.
Sept. 17, 1930 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview Cemetery
Date of Burial: Sept. 18-1930

20. Undertaker: W. W. Hansen St. Anthony Idaho.
Address

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72017

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 116
(No. 117)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elaine Jensena Glenn

(a) Residence. No. Notus, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) February 22, 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	8		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Notus, Idaho

PARENTS

10. NAME OF FATHER Denver C. Glenn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Magadelene Madson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Roswell, Idaho

14. Informant (Address) Denver C Glenn

15. Filed 9-23-, 1930. John L. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21 Oct 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 21, 1930
that I last saw h.. alive on Sept 21, 1930
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured appendix

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept 15/30
Was there an autopsy? no
What test confirmed diagnosis? Operation
(Signed) W Montgomery M. D.
Sept 21, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Ten Davis	9-23-30 19
20. Undertaker: Paul L. Case	Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72018

PLACE OF DEATH
County of Canyon
City of Huston Rt 1

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 117
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John R. Wilson
(a) Residence. No. Huston, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 14, 1861

7. AGE Years: 69 Months: 5 Days: If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) H. G. Wilson 906 N 80 Seattle Wn.

15. Filed 9-26- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 22, 1930
that I last saw him alive on Sept 21, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T. D. Farrer, M. D.
, 19 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 9-28-30 19

20. Undertaker: Paul L. Case
Address: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RE... OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72019

PLACE OF DEATH

County of Canyon
City of Caldwell, Ida

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 118
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

113

2. **FULL NAME** Harry Leonard Bicart

(a) Residence. No. Huston Rt 2 St. ...
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12, 1929

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9. BIRTHPLACE (city or town) Huston
(State or country)

PARENTS

10. NAME OF FATHER Joe Bicart
11. BIRTHPLACE OF FATHER (city or town) Kansas
(State or Country)
12. MAIDEN NAME OF MOTHER Ida Knowles
13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or County)

14. Informant (Address) Joe L Bicart

15. Filed 9-24- 1930- John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 23, 1930
that I last saw him alive on Sept 23, 1930
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
acute enteritis
infectious

... (duration) ... yrs. ... mos. 23 ds.

CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? stool
(Signed) [signature] M. D.
Sept 24, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: 9-25-30 19

20. Undertaker: Paul L. Case
Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72020

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Eagle

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sina Elizabeth Pickard. 74a
(a) Residence. No. Eagle #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Pickard

6. DATE OF BIRTH (month, day and year) Nov. 19-1856

7. AGE Years 73 Months 10 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grace Hill Iowa

PARENTS
10. NAME OF FATHER James Gatlin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alabama
12. MAIDEN NAME OF MOTHER Nancy Vanter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant (Address) Arthur J. Hadley Star, Ida

15. Filed 9-25-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to Sept 23, 1930
that I last saw him alive on Aug 5, 1930
and that death occurred, on the date stated above, at 1-30a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature] M. D.
9/23, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Star Cem
Date of Burial 9-25 1930

20. Undertaker C. V. Peckham
Address Caldwell Ida

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72021

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 120
(No.) 182
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Ray Dellinger

(a) Residence. No. Wilder Rt 1 Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 1- 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	X	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Ida

PARENTS

10. NAME OF FATHER Frank Dellinger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.

12. MAIDEN NAME OF MOTHER Marie Montagne

13. BIRTHPLACE OF MOTHER (city or town) (State or County) So Dakota

14. Informant Frank Dellinger
(Address) Wilder Rt

15. Filed 9-30-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Drowning
Accidental

No Inquest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. L. Cone, M. D.
9-29-30 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Sept 27 1930

20. Undertaker C. W. Peckham
Address Caldwell Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72022

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 121
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. **FULL NAME** Henry P. Seward
(a) Residence. No. I. O. O. F. Home St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 30, 1862

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Saline Co. Mo.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Paul L. Case
Caldwell, Idaho

15. Filed 10-8-, 1930. John S. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 2, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Oct 2, 1930
that I last saw him alive on Oct 1, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia (Uremia)

..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Carcinoma Prostate
..... (duration) 1 1/2 ~~yrs.~~ ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of No record
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
10/4, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-4-30 19

20. Undertaker	Address
Paul L. Case	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 10 '30

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72023

PLACE OF DEATH
County of Canyon
City of ~~Nampa~~ Melba
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 114
(No. 12th ave Road south Nampa
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virgil Gordon Wood
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

1614

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 28th.

AGE Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Melba
(State or country) Idaho

PARENTS
10. NAME OF FATHER Earnest Lee Wood
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Myrtle Edna Brook
13. BIRTHPLACE OF MOTHER (city or town) Klamath Falls
(State or County) Oregon

14. Informant Mr. Earnest Lee Wood
(Address) Melba, Idaho.

15. Filed 9/29, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-28, 1930, to 9-29, 1930
that I last saw him alive on 9-29, 1930
and that death occurred, on the date stated above, at 3:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Due to premature birth
.....
.....
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) J. Gordon, M. D.
9-29, 1930 (Address) Nampa.

19. Place of Burial, Cremation, or Removal	Date of Burial
Melba, Idaho.	9-29 1930
20. Undertaker	Address
Wm. D. Talley	Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5—A—25 M. 1-19. RECEIVED OCT 10 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 72024
Registered No. 713

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. State Sanitarium St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Allen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1886 (Year)

7. AGE: 44 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edith Tyson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom Bryant
(Address) Nampa Idaho

15. Filed 9-30 1930 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1 1921, to Sept 27 1930
that I last saw h[im] alive on Sept 27 1930
and that death occurred on the date stated above, at 5:45 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(Aortic insufficiency)
(Duration) Yrs. 8 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Tom Bryant M. D.
19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. 7 mos. 27 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Ontario Ore

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	9-30 1930
20. UNDERTAKER	ADDRESS
Fred K. Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72025

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 223-22nd Ave So)
Local Registrar's No. 112

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Jean Aldrich 113

(a) Residence. No. 2104 - 1st St. So. St.
(Usual place of abode.)
(If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1st 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Nampa
(State or country) Idaho

PARENTS

10. NAME OF FATHER Kenneth H. Aldrich

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) California

12. MAIDEN NAME OF MOTHER Phoebe E. Carpenter

13. BIRTHPLACE OF MOTHER (city or town) Picabo,
(State or County) Idaho

14. Informant Mr. H. E. Aldrich
(Address) Nampa Idaho

15. Filed 9-24, 1930 Estha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 23rd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sep 22, 1930, to Sep 23, 1930,
that I last saw him alive on Sept 22, 1930
and that death occurred, on the date stated above, at 5:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bacterial Enteritis

(duration) ....yrs. ....mos. 2 ds.
CONTRIBUTORY (Secondary) None
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? —

(Signed) C. C. Zellmer M. D.
9-24-1930. (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 9-24-1930

20. Undertaker: Mrs Nina M. Talley — Address: Nampa, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72026

PLACE OF DEATH
County of Owyhee.
City of Wilson.

Registration District No. 7
Primary Registration District No. 3006
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 111

164

2. FULL NAME Alfred Cox.

(a) Residence. No. Near Wilson Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jane Cox.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	5	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER James T. Cox.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER Sarah Harrison.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Lydia Mitchell
(Address) Wilson Ida

15. Filed 9/25, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 20, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Sept 20, 1930
that I last saw him alive on Sept 20, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Infirmities of age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Geo. R. Crocker M. D.
9-25, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Wilson, Ida.	
20. Undertaker F.K. Robinson.	Address Nampa Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72027

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 1006
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 110

2. FULL NAME Franklin Fisher Reeves 90

(a) Residence. No. 512, 21st Ave So St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucinda Ang

6. DATE OF BIRTH (month, day and year) Sept 17-1851

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	—	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Paquille Ohio

PARENTS

10. NAME OF FATHER Levi Reeves
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Paquille, Ohio
12. MAIDEN NAME OF MOTHER Clarinda Douglas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Paquille, Ohio

14. Informant Burton W. Reeves
(Address) Nampa, Ida

15. Filed 9/26, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1929, to Sept 8, 1930
that I last saw him alive on Sept 3, 1930
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Exhaustion from inability to retain food
Right Hemiplegia (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) acute indigestion
..... (duration) ..... yrs. ..... mos. 20 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Fox R. Proctor M. D.
Sept 26, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Z. K. Robinson	9-10 1930
20. Undertaker	Address
Nampa Undertaking Co	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72028

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 189
(No. 2 miles south Nampa
(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Mary Elizabeth Payne
(a) Residence. No. 2 miles sw Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of F. L. Payne

6. DATE OF BIRTH (month, day and year) Dec 11, 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	9	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS
10. NAME OF FATHER Thomas Saffles.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Nancy Morey.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tenn.

14. Informant (Address) Mrs. D. J. East. Nampa Idaho.

15. Filed 9/16, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28, 1930, to Sept, 1930
that I last saw her alive on Sept. 11, 1930
and that death occurred, on the date stated above, at 7½ a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute nephritis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) Samuel A Swayne M. D.
Sept. 16, 1930 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal: Star, Idaho. Date of Burial: 9-16 1930
20. Undertaker: Mrs Ina M. Talley Address: Nampa Ida

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72029

PLACE OF DEATH
County of Ada
City of 11 mi. Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 108
(No. 11 mi. N.E. Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Ellen Madsen
(a) Residence. No. 11 mi. no. E. Nampa St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Andro Madsen

6. DATE OF BIRTH (month, day and year) April 19th 1888

7. AGE Years 42 Months 4 Days 22. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS
10. NAME OF FATHER Wm B. Farmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Monroe Utah
12. MAIDEN NAME OF MOTHER Julia Ann Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Mrs. E. C. Moorhouse Boise Idaho

15. Filed 1-13, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep. (Month) 11 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-13, 1930, to 9-11, 1930
that I last saw her alive on 9-8, 1930
and that death occurred, on the date stated above, at 10.30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ✓

✓ (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed ~~diagnosis~~? ✓
(Signed) J. C. Horton M. D.
9-13, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal Rohlerlawn-Nampa
Date of Burial 9-14 1930

20. Undertaker [signature]
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72030

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

174

2. FULL NAME Robert J. Henderson

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 10-46

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith (retired)
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant: Andrew Hurley
(Address) Melba Idaho

15. Filed 9/9, 1930 Bertha Conway
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1930, to Sept 7, 1930, that I last saw h..... alive on Sept 7, 1930, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:
Acute Nephritis.
Acute Prostatitis
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Samuel A Swayne, M. D.
Sept 9, 1930 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilson Ida.	1-10-30 19
20. Undertaker	Address
F. K. Robinson	Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72031

PLACE OF DEATH
County of Canyon.
City of Nampa.

Registration District No. 7
Primary Registration District No. 1026
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 106

2. FULL NAME Wenonah Wanda Mc kechnie.

(a) Residence. No. Nampa, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem.	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jack McKechnie,

6. DATE OF BIRTH (month, day and year) 7-27-4.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
26	x& 1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk in Dept. Store.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida.

PARENTS

10. NAME OF FATHER E.K. Lewis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Anna Winkle.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida.

14. Informant Mrs Jas. Hart.
(Address) Nampa, Ida.

15. Filed Sept 4, 1930 Bertha Conroy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chest Crushed -
Auto Accident
No Jurisdiction
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Paul L Core, M. D.
9-1, 1930 (Address) Coroner Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn	9-5-30 19

20. Undertaker	Address
F.K. Robinson.	Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72032

PLACE OF DEATH

County of Canyon.

City of Nampa/

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 105

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Marie Katherine Kerwin.

(a) Residence. No. 1912-N-11-St. Boise. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jack A. Kerwin.

6. DATE OF BIRTH (month, day and year): Nov. 7, 1902.

7. AGE: 27 Years, Months 9, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Private Secretary.

(b) General nature of industry, business, or establishment in which employed (or employer): Falks Dept. Store.

(c) Name of employer: Leo J. Falk.

9. BIRTHPLACE (city or town) (State or country): Idaho.

PARENTS

10. NAME OF FATHER: Archibald Mckechnie.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Hannah Dunne.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois.

14. Informant: Mrs James Hart.
(Address): Nampa Idaho.

15. Filed Sept 4, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Head crushed
Auto accident
No Inquest

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Paul L. Case, ~~M. D.~~

9-1-, 1930 (Address) (Coroner) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Boise Idaho.

Date of Burial: 9-5-30. 19

20. Undertaker: F.K. Robinson.

Address: Nampa. Ida.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72033

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 104

140

2. FULL NAME John S. Adams
(a) Residence. No. Near Kuna Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) 9-16-68

7. AGE: Years 61 | Months 11 | Days 13 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED U.S.R.S.
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Ed Adams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant T. B. Bybee
(Address) Meridian, Idaho

15. Filed Sept 4, 1930. Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2nd, 1930, to ___, 19___
that I last saw him alive on [illegible] 2nd, 1930
and that death occurred, on the da[illegible]ve, at 3 a. m.
The CAUSE OF DEATH* was as follow[illegible]
Extensive hemorrhage into left ventricle of cerebrum.

(duration) 0 yrs. 0 mos. 10 hours ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis.
(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Symptoms & autopsy findings
(Signed) Geo. A. A. Kellogg, M. D.
Sept. 4th, 1930 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Perkins Okla | Date of Burial 19

20. Undertaker: F. K. Robinson | Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 1 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72034

PLACE OF DEATH
County of Canyon
City of Parma

Registration District No. 3
Primary Registration District No. 2007
(No.)
Local Registrar's No. 1

(If death occurred in a hospital or institution, give its name instead of street and number.)

161B

2. FULL NAME Baby Young.

(a) Residence. No. Parma Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) August 31-1930

7. AGE	Years	Months	Days	If LESS than 1 day, One hrs. or min.
	—	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Parma Idaho

PARENTS

10. NAME OF FATHER B H Young.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jane. Mo.
12. MAIDEN NAME OF MOTHER Belle Goff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jane Mo.

14. Informant B. H. Young
(Address)

15. Filed 9-2, 1930 Mabel Isaacs Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Aug 31, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 5. a. m.
The CAUSE OF DEATH* was as follows:
Stillborn

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prolapsed cord.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? —
(Signed) C M. Mitchell, M. D.
8/31, 1930 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
E V Peckham	Parma Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72035

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 2
(No. 133)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Emeline Eakley

(a) Residence. No. 1 Parma #2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 9 - 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lansing Iowa

PARENTS

10. NAME OF FATHER Gotlieb Engleborn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Jane Vaudyke
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant Walter Matthews
(Address) Parma Ida

15. Filed Oct 10, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 27, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to June 27, 1930
that I last saw her alive on June 26th, 1930
and that death occurred, on the date stated above, at 3 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Jaundice due to gall stones

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes No Date of June 24th.
Was there an autopsy?
What test confirmed diagnosis? Operation
(Signed) J. S. Springer, M. D.
8/1, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Sunset Cem	6-30 1930
20. Undertaker	Address
E. V. Peckham	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72036

PLACE OF DEATH
County of Bonneville
City of Soda Springs
Registration District No. 82
Primary Registration District No. 2-159
Local Registrar's No. 27
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1946

2. FULL NAME George E Esther Tyler

(a) Residence. No. Clinton Okla. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of George Tyler
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mch. 9- 1902

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	6	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) Waitress
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dill City Okla.

PARENTS

10. NAME OF FATHER Ed. Hackathorn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Alice McCowan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George Tyler
(Address) Clinton Okla.

15. Filed 9-24, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1930, to after death
that I last saw him alive on , 19
and that death occurred, on the date stated above, at about 5:30 P. m.

The CAUSE OF DEATH* was as follows:
Internal Chest injuries
(exact nature undetermined)
from automobile accident
(duration) yrs. mos. 1 hr.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Just over Bear Lake Co line.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Ex. Body
(Signed) Russell Tigert, M. D.
Sept 24, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 9-25-1930

20. Undertaker E. L. Whitemore — Address Soda Springs Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72037

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

71a

2. FULL NAME George Adam Thomas.
(a) Residence. No. Hazelton, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Gillian Ann France

6. DATE OF BIRTH (month, day and year) Aug. 11 - 1862

7. AGE Years 68 Months 1 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Howard Bodenheimer

9. BIRTHPLACE (city or town) (State or country) Boone ville Ky.

PARENTS
10. NAME OF FATHER Lafayette Thomas.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Rebecca Hall.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. M. Reynolds.
(Address) Kimberly Idaho.

15. Filed 9-16, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 3, 1930, to Sep. 16, 1930
that I last saw him alive on Sep 16, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Meningitis
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Fractus Sinus Innominat
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? 0
Did an operation precede death? 0 Date of 9/10/16
Was there an autopsy? 0
What test confirmed diagnosis? X-Ray
(Signed) Chris Kas. Hay, M. D.
9/17/30, 19 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hazelton Idaho. Date of Burial 9-20-1930

20. Undertaker E. D. Whiteman Address Soda Springs. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72038

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 25

49

2. FULL NAME Harry Grant Hauselman
(a) Residence. No. Gooding Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Hauselman

6. DATE OF BIRTH (month, day and year) Feby 12-1870

7. AGE Years 70 Months 6 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Peter Hauselman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Susan Kelly
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Evelyn Hauselman
(Address) Gooding Idaho.

15. Filed 9-8- 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 1, 1930, to Sep 8, 1930
that I last saw him alive on Sep 8, 1930
and that death occurred, on the date stated above, at 10 9 m.
The CAUSE OF DEATH* was as follows:
Causes of Bladder
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes Date of Sep 1, 1930
Was there an autopsy? 0
What test confirmed diagnosis? Cystoscopic
(Signed) Eric Kaeseley, M. D.
9/8/30, 19 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Gooding Idaho
Date of Burial 9-11- 1930

20. Undertaker C. S. Wietman
Address Soda Springs Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72039

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No.) .34
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

2. FULL NAME Artie N. Johnson
(a) Residence No. Central Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Loretta Johnson

6. DATE OF BIRTH (month, day and year) Mar 10 - 1895

7. AGE Years 35 Months 5 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carl Junction Mo.

PARENTS

10. NAME OF FATHER Edward Fisher Johnson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lebenon Mo
12. MAIDEN NAME OF MOTHER Sarah Alice Wilfmore
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Springgarden Illinois

14. Informant Fred Indiman
(Address) Central Idaho

15. Filed 9-1- 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Aug 31, 1930
that I last saw her alive on Aug 31, 1930
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonalis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Central Ida
Did an operation precede death? 0 Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? T. B. Sud in Sherlin
E.T. (Signed) Ellis Kaisky, M. D.
9/3 1930 (Address) Soda Spring Idaho
Aug 31 1930

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Central Ida
Date of Burial Sept 3 1930
20. Undertaker
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72040

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

195

2. FULL NAME Pedro Arbulu
(a) Residence. No. Pocatello Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 35 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep herder.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Frank Jongelord.

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spain
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spain.

14. Informant S. Emilior
(Address) Pocatello Idaho

15. Filed 8-28, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Killed by Lighting
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? 0 Date of
Was there an autopsy? 0
What test confirmed diagnosis?
(Signed) Eric Kaskey, M. D.
8-28, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pocatello Idaho
Date of Burial 8-29-1930

20. Undertaker E. D. Whitman
Address Soda Springs Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72041

PLACE OF DEATH
County of Caribou
City of Conda

Registration District No. 82
Primary Registration District No. 2159
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

74a

2. FULL NAME ~~Tom~~ Thomas H. Rose
(a) Residence. No. Inkom Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6, 1875

7. AGE Years 55 Months 2 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER John Rose
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Perlina Fife
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant John Tasmin
(Address) Conda Idaho.

15. Filed Sept 4, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19, to —, 19
that I last saw h alive on —, 19
and that death occurred, on the date stated above, at 945a m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
(duration) — yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? 0 Date of ✓
Was there an autopsy? 0
What test confirmed diagnosis? —
(Signed) Ellis Kaisley, M. D.
9/4/30, 19 (Address) Side Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal American Falls Ida
Date of Burial Sept 7 1930

20. Undertaker A W Davis
Address American Falls Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19 RECEIVED OCT 4 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72042

Local Registrar's No.

1. PLACE OF DEATH

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 2168

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Howard Clayton Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: February (Month) 15 (Day) 1924 (Year)

7. AGE: 6 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Carl Johnson

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Anna Vevle

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl Johnson

(Address) Elk River Idaho

15. Filed Oct 1 1930 Mildred Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH 182

16. DATE OF DEATH: August (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15 1930, to Aug 15 1930, that I last saw him alive on August 13 1930, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O M Husted M. D.

Aug. 16 1930 (Address) Elk River, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River, Idaho.

DATE OF BURIAL: Aug. 17 1930

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72043

Registration District No. 90
Primary Registration District No. 2167
Local Registrar's No. 64

90

PLACE OF DEATH

County of Clearwater
City of Orofino

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Dick Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) Lincoln
(State or country)

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) —
(State or Country)

14. Informant V. A. Shaw Coroner
(Address) Orofino

15. Filed 9/24, 19.. V. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 24 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19.., to ....., 19..
that I last saw h.. alive on ....., 19..
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:

Labor Heart Disease

.....(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) ..yrs. ..mos. ..ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) V. A. Shaw Coroner M. D.
9/24, 19.. (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	9/26 19
20. Undertaker	Address
V. A. Shaw	Orofino

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72044

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 65
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alberta May Sharp 30

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

8. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14th 1930

7. AGE — Years: | Months: 4 | Days: 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Orofino Ida

PARENTS

10. NAME OF FATHER Albert T. Sharp
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alaska
12. MAIDEN NAME OF MOTHER Mary Ellen Coghill
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cashmere Washington

14. Informant Albert T. Sharp
(Address) Orofino

15. Filed Sep 17, 19..... W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-9-, 1930, to 9-15-, 1930
that I last saw her alive on 9-15-, 1930
and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:
Convulsions -
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pneumonia - Flue Involved
Malnutrition (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) W. T. Robertson, M. D.
9-15-, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	9/16 19
20. Undertaker	Address
W. D. Pinson	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72045

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 64
(No.) 119
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earnest Lee Munk

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 10 1927

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	3	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Oscar Munk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Olsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Oscar Munk
(Address) Orofino

15. Filed Sep 13, 19 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 6, 1930, to Sept. 12, 1930
That I last saw him alive on September 12, 1930
and that death occurred, on the date stated above, at 11:50 P. m.
The CAUSE OF DEATH* was as follows:
Diarrhea - Colitis - acute -
(Flu)
(duration) yrs. mos. 6 ds.
CONTRIBUTORY Pertussis
(Secondary)
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) H. R. Patterson, M. D.
9/15, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino. Ida -	Sept 14 19

20. Undertaker	Address
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72046

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 63
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Vikstrom

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 55			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clearwater Timber Co

9. BIRTHPLACE (city or town) (State or country) ~

PARENTS
10. NAME OF FATHER ~
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~
12. MAIDEN NAME OF MOTHER ~
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ~

14. Informant W. A. Shaw Coroner
(Address) Orofino Ida

15. Filed Sept 8, 1930. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 7 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1929 to Sept. 7, 1930
that I last saw him alive on Sept. 6, 1930
and that death occurred, on the date stated above, at 6:30 a m.
The CAUSE OF DEATH* was as follows:

Valvular heart disease
(duration) several yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute endocarditis
(duration) yrs. 4 mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) P. T. Hoffeins M. D.
9/8/30, 19 (Address) Orofino, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Sept 9 19
20. Undertaker W. A. Shaw	Address Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72047

PLACE OF DEATH

County of Custer
City of Clayton

CERTIFICATE OF DEATH

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 105
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Hobbs Sullivan

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Cornelius Joseph Sullivan

6. DATE OF BIRTH (month, day and year) Aug 19 1862

7. AGE Years 68 Months 11 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10. NAME OF FATHER William Hobbs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Lillie Barrett
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Phil C. Sullivan

15. Filed July 25, 1930 Elna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no medical attendant, 19..... that I last saw h..... alive on did not see her and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Endarteritis

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. L. Kirtley, M. D.
(Health officer) 19.. (Address) Challis, Ida.

19. Place of Burial, Cremation, or Removal Clayton, Idaho — Date of Burial July 26 1930

20. Undertaker Relatives — Address Clayton, Ida.

RECEIVED SEP 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72048

PLACE OF DEATH
County of Custer
City of Stanley

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 106
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME Elmer Casto

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17, 1895

7. AGE Years 35 Months 3 Days 5 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hailey Idaho

PARENTS
10. NAME OF FATHER W. H Casto
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Blanche Parrott
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho Ill

14. Informant (Address) Frank Casto Custer Ida

15. Filed Aug 22, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Death by accidental drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) no doctor in attendance, M. D.
(Address)

19. Place of Burial, Cremation, or Removal Hailey, Idaho
Date of Burial Aug. 23 1930

20. Undertaker J. L. Ebbets (coroner)
Address Challis, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

PLACE OF DEATH

County of Elmore

City of Glenns Ferry

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 33

Primary Registration District No. 2021

DO NOT WRITE IN THIS SPACE

State File No. 72050

Local Registrar's No.

(No. 92)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Clara Agnes Smith

(a) Residence. No. Glenns Ferry Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Benj. F Smith

6. DATE OF BIRTH (month, day and year): June 12 - 1873

7. AGE: Years 55 | Months 2 | Days 27 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Farming Minn

PARENTS

10. NAME OF FATHER: John Stammen

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Caroline Woelke

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs Frances Botz

(Address) Bend Oregon

15. Filed 9-14, 1930. Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1930, to Sept. 9, 1930

that I last saw h alive on Sept. 9, 1930

and that death occurred, on the date stated above, at 6:45 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Phlebitis Left leg

(duration) yrs. mos 4 6 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. W. Davis, M. D.

Sept. 10, 1930 (Address) Glenns Ferry Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Glenns Ferry Ida	9-10 1930

20. Undertaker	Address
G C Zacher	Mt Home Ida

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72051

PLACE OF DEATH

County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No. 172)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adelia Mae Hilty

(a) Residence. No. (Usual place of abode) St. Indian Cove, Id
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, ~~Married, Widowed,~~ or ~~Divorced (write the word)~~: Single - Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 11 - 1925

7. AGE: Years 5 | Months | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9. BIRTHPLACE (city or town) (State or country): Nampa, Canyon Co.

PARENTS

10. NAME OF FATHER: Geo. B. Hilty
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown Ohio
12. MAIDEN NAME OF MOTHER: Hannah Showalter
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Virginia Showalter
(Address): Indian Cove Idaho

15. Filed 9-9-, 1930 Mrs Mary L. Sullivan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6 (Day) 19 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 19 30 to Sept 6, 19 30
that I last saw h alive on Sept 6, 19 30
and that death occurred, on the date stated above, at 9:15 p.m.
The CAUSE OF DEATH* was as follows:
Cholera Infantum 1
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Clinical M. D.
9/7, 19 30 (Address) Glenns Ferry

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Glenns Ferry Ida — Date of Burial: 9/7/30
20. Undertaker: D. C. Barker — Address: Glenns Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72052

PLACE OF DEATH
County of Elmore
City of Glenns Ferry
Registration District No. 35
Primary Registration District No. 2021
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Walter Grant Corker

(a) Residence. No. Glenns Ferry Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6. DATE OF BIRTH (month, day and year) Nov 2 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Game Warden
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer State of Idaho

9. BIRTHPLACE (city or town) (State or country) Rock Island Ill.

PARENTS

10. NAME OF FATHER John Corker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Margaret Corker
(Address) Glenns Ferry Ida

15. Filed 9 - 12, 1930 Mrs Mary Sullivan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 19. 1930, to Sept 8. 1930
that I last saw him alive on Sept 8, 1930
and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
(duration) yrs. mos. 21 ds.
CONTRIBUTORY (Secondary) Gastric Ulcer
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. W. Davis, M. D.
Sept. 9, 1930 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Glenns Ferry Ida	9 - 12 1930

20. Undertaker S. C Zacher Mt Home Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72053

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 62

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME Grant Samuel Green

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Delia S. Green

6. DATE OF BIRTH (month, day and year) May 30 1863

7. AGE Years 67 Months 3 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Dwain Green

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Clara M. Green

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant Mrs Glen Jensen

(Address) Riverdale Idaho

15. Filed 9/14/30, 19.... [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1st, 1930, to Sept 11, 1930 that I last saw him alive on Sept 11, 1930 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows: Abscess of the liver following an acute appendicitis

..... (duration) ..... yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho

Date of Burial: Sept 14 1930

20. Undertaker: M. W. Hendricks

Address: Preston

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72054

PLACE OF DEATH
County of Treasureton
City of Franklin

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 63

(No. 44)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Soren Joseph Nelson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elmyra J. Nelson

6. DATE OF BIRTH (month, day and year) Jan 10 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	8	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Christena Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Glen Nelson
(Address) Treasureton Idaho

15. Filed 9/19/, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Sept 17, 1930
that I last saw him alive on Sept 15, 1930
and that death occurred, on the date stated above, at 8 30 P m.
The CAUSE OF DEATH* was as follows:
Cancer of stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Error
(Signed) Thos A Holder, M. D.
Sept 18, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Treasureton Idaho	Spet 19 19

20. Undertaker M.W.Hendricks Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72055

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 65

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriet A. Nielsen

(a) Residence. No. 56 No. 1st East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: wh.
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 30 1889

7. AGE 41 Years | 5 Months | 28 Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bookkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Logan Utah

PARENTS

10. NAME OF FATHER: E. R. Nielsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salt Lake Utah
12. MAIDEN NAME OF MOTHER: Mary Parry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake Utah

14. Informant: H. A. Nielsen
(Address): Preston

15. Filed 10/1/30, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-22., 1930, to Sept 27, 1930.
that I last saw h[illegible] alive on Sept 27, 1930.
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Grave Disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 1922
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. H. Curtis M. D.
, 19... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Logan, Utah — Date of Burial: Sept. 30 1930
20. Undertaker: G. W. Sundquist — Address: Logan, Ut.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 62056

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

168

2. FULL NAME Venna B. Sakurai

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Chester Sakurai

6. DATE OF BIRTH (month, day and year): May 23 1904

7. AGE: Years 26, Months 4, Days 3. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Gentlevalley Idaho

PARENTS

10. NAME OF FATHER: Newman Blodgett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ogden Utah
12. MAIDEN NAME OF MOTHER: Laura Marble
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Severe County Utah

14. Informant: Chester Blodgett [illegible] Sakurai [illegible]
(Address) Ogden Utah

15. Filed 9/24/30, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-17-30, 19, to 9-20-30, 19
that I last saw her alive on 9-20-30, 19
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Cellulitis of neck following extraction of mid molar tooth
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. R. Cutler, M. D.
9/24/30, 19 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho
Date of Burial: Sept 24 19

20. Undertaker: M. W. Hendricks
Address: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72057

PLACE OF DEATH

County of Franklin
City of Mapleton

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 61

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4H

2. FULL NAME Ida Sharp

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27 1910

7. AGE	Years	Months	Days	If LESS than 1 day,
	11	1	20	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Mapleton Idaho

PARENTS

10. NAME OF FATHER Joseph T Sharp

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tooele Utah

12. MAIDEN NAME OF MOTHER Anna Woodhead

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Joseph T Sharp
(Address) Mapleton Idaho

15. Filed Sept 10, 1930 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 –, 1930, to Sept 8, 1930
That I last saw her alive on Sept 8 –, 1930
and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:
Brain Tumor growing at base of brain - Neurofibroma - Diagnosis Confirmed by autopsy
(duration) 1 yrs. – mos. ds.

CONTRIBUTORY (Secondary) Symptoms developed after scarlet fever 1 year ago
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? –
Did an operation precede death? No Date of –
Was there an autopsy? Yes Autopsy –
What test confirmed diagnosis? .....
(Signed) G. W. Stites M. D.
Sept 10, 1930 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Sept 10 30

20. Undertaker	Address
M.W. Hendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

PLACE OF DEATH

County of Gem

City of Emmett

CERTIFICATE OF DEATH

Registration District No. 6

Primary Registration District No. ____

(No. ____)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72058

Local Registrar's No. ____

162

2. FULL NAME Patty Lue Rice

(a) Residence. No. ____ St. ____

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept. 3 1930

7 AGE — Years: | Months: | Days: 2 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Emmett Idaho

PARENTS

10 NAME OF FATHER Elmer John Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Goding Idaho

12 MAIDEN NAME OF MOTHER Beulah Mae Veach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Marion Mich.

14 Informant Elmer John Rice

(Address)

15 Filed 10-2, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 5 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-3, 1930, to 9-5, 1930, that I last saw her alive on 9-5, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

convulsion

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. R. Emmett, M. D.

9-6, 1930 (Address) Emmett

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Emmett. Date of Burial: Sept. 6, 1930

20. Undertaker: C. H. Yarlett Address: Emmett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72059

RECEIVED OCT 4 1930

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Gem
City of Emmett
Registration District No. 4
Primary Registration District No. ____ Local Registrar's No. ____
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Levi Alonzo Van Natta

(a) Residence. No. ____ St. ____
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. ____ mos. 10 ds. How long in U. S. if of foreign birth? yrs. ____ mos. ____ ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Mary Alice Van Natta

6. DATE OF BIRTH (month, day and year) Feb. 22 1861

7. AGE Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
69	8	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General farm work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Aron Van Natta
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary J. Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) C A Van Natta Emmett Idaho RFD #3

15. Filed 10-2-, 1930 J L Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2nd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from after death and ____, 19____
that I last saw h[illegible] alive on after death Sept 19____
and that death occurred, on the date stated above, at 6 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Chronic Asthma several years
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Idaho
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? medical

(Signed) J L Reynolds, M. D.
10/2/, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal: Payette Idaho — Date of Burial: Oct 5 1930

20. Undertaker: Glenn C Sanders — Address: Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED OCT 4 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72060

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. .....

Primary Registration District No. 6 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** Ephram James Campbell

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23-1850

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	10	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Lafayette Co
(State or country) Missouri

PARENTS

10. NAME OF FATHER Aaron Campbell

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER Sophia Defreece

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Penn

14. Informant Bertha E. Norwood
(Address)

15. Filed 9/24, 1930 J. K. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Sept 17, 1930, to Sept 20, 1930
that I last saw him alive on Sept 19 a, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

Three days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

Cardiitis (duration) Several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. K. Reynolds, M. D.

9/22, 1930 (Address) .....

19. Place of Burial, Cremation, or Removal: Nelson, Neb — Date of Burial: 19

20. Undertaker: O. D. Bucknum — Address: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72063

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. .....
Primary Registration District No. 6 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME George E. Williams

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Dora E. Williams

6. DATE OF BIRTH (month, day and year) July 25-1868

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Well Digger
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Ohio

PARENTS

10. NAME OF FATHER William Williams

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Anna Esser

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) Not Known

14. Informant (Address) Dora E Williams

15. Filed 9/6, 1930 J. K. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Sept 4, 1930, that I last saw him alive on July 28, 1930, and that death occurred, on the date stated above, at 8 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at Emmett
Did an operation precede death? No Date of none
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. K. Reynolds M. D.
9/6, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 9/6 1930

20. Undertaker: C. D. Buckner — Address: Emmett Idaho

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72063

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 6

Primary Registration District No. _____ Local Registrar's No. 119

(No. _____)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Venetta Madeline Cline

(a) Residence. No. _____ St. _____
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	white	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 22 - 1929

7. AGE Years	Months	Days	If LESS than 1 day ____ hrs. or ____ min.
1	4	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kingston Mo

PARENTS

10. NAME OF FATHER C. A. Cline

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Polo Mo

12. MAIDEN NAME OF MOTHER Pearl Russell

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kingston Mo.

14. Informant C A Cline
(Address)

15. Filed 9/6, 1930. J L Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 5, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Sept 1, 1930, to Sept 5th, 1930, that I last saw h-- alive on Sept 5, 1930, and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Emmett
Did an operation precede death? no Date of _____
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J L Reynolds, M. D.
9/6, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	9/6 1930

20. Undertaker C Bucknum
Address Emmett Idaho

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH OCT 3 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.

County of

Primary Registration District No. 24

File No. 72063

City of

(No. , St.)

Registered No. 536

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME June Hobdey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 9 (Month) 2 (Day) 1930 (Year)

7. AGE: — Yrs. — Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Co Ida

10. NAME OF FATHER: Earl E. Hobdey

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Alice E. Pruett.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ida M Hobdey
(Address) Bliss Idaho

15. Filed 9-[illegible] 1930 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 6 (Day) 1930 (Year)

16th

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2 1930 to Sept. 6 1930 that I last saw h[illegible] alive on Sept. 5 1930 and that death occurred on the date stated above, at 9:00 A. M.

The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Houston E. Snyder M. D.

9-6 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72064

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 25
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Isabell Pearson 117

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1911

7. AGE Years 19 Months Aug Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville

PARENTS
10. NAME OF FATHER Thomas Pearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dalle Oregon
12. MAIDEN NAME OF MOTHER Oliver
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pomrow Wash

14. Informant (Address) Thomas Pearson

15. Filed 10-1-, 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28, 1930, to Sept 13, 1930
that I last saw her alive on Sept 13, 1930
and that death occurred, on the date stated above, at 11 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Appendicitis
..... (duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary) Ruptured
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 9-5-30
Was there an autopsy? No
What test confirmed diagnosis? Rev - abdomen
(Signed) B Chipman, M. D.
9-16-, 1930 (Address) Grangeville Ida

19. Place of Burial, Cremation, or Removal Grangeville Ida
Date of Burial 9-15- 1930

20. Undertaker Hancock Mnd. Co.
Address Grangeville

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72065

Local Registrar's No. 24

746

PLACE OF DEATH

County of Idaho
City of Grangeville
Registration District No. 103
Primary Registration District No. 1001
(No. At Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William R. Briscoe

(a) Residence. No. Grangeville St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Elida Briscoe

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	2	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER John W. Briscoe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Arkansas
12. MAIDEN NAME OF MOTHER Margaret Burgin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. C.

14. Informant Elida Briscoe
(Address) Grangeville

15. Filed 10-1-, 1930 J. B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to Sept. 12, 1930
that I last saw ~~him~~ alive on Sept 12, 1930
and that death occurred, on the date stated above, at 3: P. m.
The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage
Sudden
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Hypertension
(Signed) J. B. Chipman, M. D.
9-14-, 1930 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Prairie View	9/14 1930
20. Undertaker	Address
Vassar	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72066

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 23

PLACE OF DEATH

County of Idaho
City of Grangeville
(No. 503 College)
(If death occurred in a hospital or institution, give its name instead of street and number.)

740

2. FULL NAME Alice Hdora Rush

(a) Residence. No. 503 College St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. P. Rush.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carlton Arkansas

PARENTS

10. NAME OF FATHER John C. Mottox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. C.
12. MAIDEN NAME OF MOTHER Talitha Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. John Chance
(Address) Grangeville

15. Filed 10-1-, 1930 V B Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4, 1930, to Sept. 6, 1930
that I last saw her alive on Sept. 6, 1930
and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) V. B. Chipman, M. D.
9-8-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	9-11- 1930
20. Undertaker Vasson	Address City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 72067

Registered No. 13

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter William Mader

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 17 (Day) 1923 (Year)

7. AGE: 7 Yrs. 4 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph C. Mader

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Elizabeth Beckman

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sophia M. Mader

(Address) Green Creek Idaho

15. Filed Sept. 6 1930 W. F. Ord per J. B. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

114

16. DATE OF DEATH: Sept. (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1930 to Sept. 5 1930 that I last saw h.im alive on Sept. 1 1930, and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis.

(Duration) about 2 Yrs. mos. ds.

Contributory (Secondary): not definitely known.

(Duration) yrs. mos. ds.

(Signed) F. E. Ellison M. D.

9-6-1930 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cottonwood, Idaho	9-7 1930
20. UNDERTAKER	ADDRESS
Fo. Hillibrand	Cottonwood, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 72068

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Lord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 19 (Day) 1851 (Year)

7. AGE: 79 Yrs. 7 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: William Boyer

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Nancy Mallory

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel Lord Zehner

(Address) Boles, Idaho.

15. Filed Sept. 13 1930 W. F. Orr per I. B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

44

16. DATE OF DEATH: Sept (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1930, to Sept 12 1930, that I last saw her alive on Sept 12 1930, and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of liver.
(Under my care 4 months + 1 week)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Woodcock M. D.

9-13-1930 (Address) Cottonwood, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. ~~PLACE OF BURIAL OR~~ REMOVAL: Ellery, Illinois

DATE OF BURIAL: Sept 14 1930

20. UNDERTAKER: Brown & Wann

ADDRESS: Lewiston, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 11 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

File No. 72069

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karl Heinz Hinkalman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Feb (Month) 22 (Day) 1913 (Year)

7. AGE 17 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Adolph Hinkalman

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Helen Lohmann

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adolph Hinkelman

(Address) Greencreek

15. Filed Sept. 18 1930 W. F. Orr Local Registrar

I. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 107

Sept (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1930, to Sept 16 1930, that I last saw him alive on Sept 16 1930, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Quinsy

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Pleurisy + Empyaemia

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) G. A. Woodcock M. D.

9-18-1930 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood

DATE OF BURIAL: 9-18-1930

20. UNDERTAKER: Brower + Wann

ADDRESS: Lewiston, Ida

SYMS - YORK CO., PTRS. & SDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72070

PLACE OF DEATH
County of Jefferson
City of Lorenzo

Registration District No. 98
Primary Registration District No. 7176.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48B

2. **FULL NAME** Martin V. Wyant

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 10½ 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	-	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) for Self
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carlton, Ohio.

PARENTS

10. NAME OF FATHER Wm Wyant

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Eliza Lange

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs. Amanda McNeilly
(Address) Ida Falls Idaho

15. Filed 10/8, 1930 A O Eckwall Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 (?) 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Myocarditis
Chr. Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A B Ingley, M. D.
Oct 7, 1930 (Address) Lorenzo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelton Ida.	Oct 9th 1930

20. Undertaker	Address
Ivan J Keller	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72071

PLACE OF DEATH

County of Jefferson
City of Pirie

Registration District No. 98
Primary Registration District No. 2176
(No. None)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48

2. FULL NAME Joseph Hewitt

(a) Residence. No. Pirie St.
(Usual place of abode)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Mary Hewitt

6. DATE OF BIRTH (month, day and year) Jan 14 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	8	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Machinist
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Francis Hewitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Mary Dean
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Mary Hewitt
(Address) Pirie Idaho.

15. Filed 10/8, 1930 J. P. Richards Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22, 1930, to Oct 4, 1930
that I last saw h alive on Oct 4, 1930
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Arteriosclerotic)
Unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute pulmonary Oedema
30 min.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical and Laboratory.
(Signed) H. K. Abbott, M. D.
Oct 8, 1930 (Address) Kirie Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	Oct. 1930
20. Undertaker V. F. M Han	Address Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72072

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176 . Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Cynthia Romina Slater.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 36 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of James Henry Slater.

6. DATE OF BIRTH (month, day and year) March 3 1863

7. AGE Years 67 Months 6 Days 11 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Edward Gillson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER C. R. Drake.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ~~Iowa.~~ Penn.

14. Informant (Address) Wm Haddon Lorenzo, Idaho.

15. Filed 9/15, 1930 A B Eckersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 14, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Sept 14, 1930
that I last saw her alive on Sept 2, 1930
and that death occurred, on the date stated above, at 11:40 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
, 19 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal Annis. Idaho
Date of Burial 9/16/30 19

20. Undertaker A B Eckersell Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72073

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. **FULL NAME** Helen Fay Olsen.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Babe,

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Babe

6. DATE OF BIRTH (month, day and year) March 30, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg, Idaho.

PARENTS

10. NAME OF FATHER LaVerl Olsen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rigby, Idaho.

12. MAIDEN NAME OF MOTHER Mary Ellen Westergard.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Rigby, Idaho.

14. Informant LaVerl Olsen
(Address) Rigby, R. #1

15. Filed 9/18, 1930 A B Eckersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 17 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Entero-Colitis

.....(duration) .....yrs. .....mos. 3 ds.
CONTRIBUTORY (Secondary) Malnutrition
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. R. West, M. D.
9/18, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 9/17 1930

20. Undertaker A B Eckersell Address: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1930

PLACE OF DEATH

County of Jerome

City of Jerome

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

(No. 44)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72075

Local Registrar's No.

2. FULL NAME Milton Frank Ikard

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Virginia Ikard

6. DATE OF BIRTH (month, day and year) Oct. 9/1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	74	11	9	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Franklin Co, Tenn

PARENTS

10. NAME OF FATHER Elijah H. Ikard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Un. S. Ca.

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant W. L. Ikard

(Address) Jerome Ida

15. Filed 9/18, 1930 C. F. Zeller
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to Sept 18, 1930
that I last saw h[illegible] alive on Sept, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. F. Zeller, M. D.

9/18, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Gooding. Ida	
20. Undertaker	Address
[illegible]	

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72076

PLACE OF DEATH
County of Twin Falls
City of

Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

#9

2. FULL NAME Severt Severson
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Balah Severson

6. DATE OF BIRTH (month, day and year) Dec 11

7. AGE Years 57 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Carl Swenson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Helena Iverson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Jo K Peterson
(Address) Jerome Idaho

15. Filed Sept 11, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Sept 8th, 1930, that I last saw him alive on Sept 8th, 1930 and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows: (1) Carcinoma - Pancreas (head) (2) obstruction Common bile duct - Jaundice Severe (3) Infection liver - (4) Malaysia severe,
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Suppression wine.
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Stockton Calif.
Did an operation precede death? YES Date of Sept 2nd/30
Was there an autopsy? no
What test confirmed diagnosis? Operation Examination
(Signed) Duncan K Hexander, M. D.
Sept 10, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome Cem
Date of Burial Sept. 11 1930

20. Undertaker
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72077

PLACE OF DEATH

County of Twin Falls
City of ✓ ✓
Registration District No. 18
Primary Registration District No.
(No. Twin Falls County General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

47

2. FULL NAME Edna Elberta Garner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Woman	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 28 - 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	11	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Henry Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Lucile Lawrence
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Henry Garner
(Address) Jerome Idaho

15. Filed Sept 18, 1930 Chas F. Zeller. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to July 16, 1930, that I last saw her alive on July 16, 1930, and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:
Pericarditis with Effusion,
Myocarditis
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Endocarditis with Nephritis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. E. Faust, M. D.
Sept 10, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL:

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Cemetery	July 18 1930
20. Undertaker	Address
E. L. Harrison	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72078

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1930 D

2. FULL NAME Ruth Edele Kennedy

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Jan 2 - 1916

7. AGE: Years: 14 | Months: 8 | Days: 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Seattle Wash

PARENTS

10. NAME OF FATHER: Earl F Kennedy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): York Nebr
12. MAIDEN NAME OF MOTHER: Hellen Edith Eggleston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Exeter Nebr

14. Informant: Earl F Kennedy
(Address): Jerome

15. Filed 9/29, 1930. Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on
and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Killed in the plane crash body burned when airplane burned up.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) J R Wiley Coroner
9-29, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Cemetery	Sept 1930
20. Undertaker	Address
D A Efferson	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

PLACE OF DEATH

County of Jerome

City of Jerome

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72079

Local Registrar's No.

1880

2. FULL NAME Marjorie Estelle Candee

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): July 4 1908

7. AGE: Years 22 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Sectary.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kasson Minn.

PARENTS

10. NAME OF FATHER: Leon P Candee

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kasson Minn

12. MAIDEN NAME OF MOTHER: Elizabeth Barholz

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Painesville Minn

14. Informant: Leon P Candee
(Address) Jerome

15. Filed 9/29, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on

and that death occurred, on the date stated above, at 6-40 P. m.

The CAUSE OF DEATH* was as follows:

Killed in Air plain crash, body burned when air plain burned up

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) J R Wiley Coroner M.D.

9-29, 1930 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery

Date of Burial: Oct 1 1930

20. Undertaker: D A L Herrisson

Address: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72080

PLACE OF DEATH
County of Jerome
City of

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

60 B

2. FULL NAME Evelyn Osterloh
(a) Residence. No. 4 3/4 south of Jerome St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 6-

7. AGE 68 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS
10. NAME OF FATHER Daggert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Ben O'Harrow
(Address) Jerome, Ida.

15. Filed Aug 30, 1930. Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/15, 1930, to 8/29, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2:30 P.m.
The CAUSE OF DEATH* was as follows:
Toxic Goiter
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Dropsy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Saul F Price, M. D.
8/29, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: 8-31 1930

20. Undertaker: White Mortuary Inc
Address: Twin Falls, Ida

RECEIVED SEP 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72081

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. 16
Primary Registration District No.
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

49B

2. FULL NAME Helen Rebecca Carlton

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of L. D. Carlton

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home work
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS
10. NAME OF FATHER Geo. Strong
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Emma Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Conn.

14. Informant L. D. Carlton
(Address) Jerome Ida.

15. Filed Aug 25, 1930 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1924, to Aug, 1930
that I last saw h[illegible] alive on Aug 23, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
Chronic Interstitial Nefritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Bronchitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas F. Zeller, M. D.
8/24, 1930 (Address) Jerome, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Cemetery	Aug 26 1930
20. Undertaker White Mortuary	Address Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72082

PLACE OF DEATH
County of Jerome
City of Eden

Registration District No. 23
Primary Registration District No. 2017
(No. 112)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willard Grant Walteum

(a) Residence. No. Eden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 15/1929

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	8	28	

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER W S Walbyn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Fern Vineyard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant B C Ringgold
(Address) Eden

15. Filed Oct 1, 1930 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 13, 1930
that I last saw him alive on Sept 13, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Cholera infantum.

(duration) — yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) H W Lundvall, M. D.
Sept 13, 1930, (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hazelton — Date of Burial Sept 14 1930
20. Undertaker F C Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED SEP 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72083

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. 4H)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anthony McCabe Kerr

(a) Residence. No. Connelly Hospital St. Redmont Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Myra Kerr

6. DATE OF BIRTH (month, day and year) 1862 8-15

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	1	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ashland, Wis.

PARENTS

10. NAME OF FATHER W= Kerr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Dorothy Maitland
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept 17, 1930
that I last saw h~~im~~ alive on Sept 16 1930
and that death occurred, on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.
(duration) 1 yrs. + mos. + ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) H W Shryock, M. D.
Sept 18, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Medemont Idaho	9-19 1930
20. Undertaker	Address
Cassedy Funeral Home	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.....

Registration District No. 126

Primary Registration District No. 2304

Local Registrar's No. 12

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Kootenai

City of Harrison

2. FULL NAME Anthony McCabe Kerr

(a) Residence. No..... St.....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug. 15-1862

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	1	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor.

(b) General nature of industry, business, or establishment in which employed (or employer) Logging.

(c) Name of employer Retired.

9. BIRTHPLACE (city or town) (State or country) Ashland, Wisconsin

PARENTS

10. NAME OF FATHER William Kerr

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Doesn't know.

12. MAIDEN NAME OF MOTHER Doesn't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Doesn't know.

14. Informant Dorothy Maitland

(Address)

15. Filed Sept 19, 1930. H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15, 1930, to Sept. 16, 1930

that I last saw him alive on Sept. 16, 1930

and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(duration) 1 yrs. + mos. + ds.

CONTRIBUTORY —
(Secondary)

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H W Shryock, M. D.

Sept 19, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Medimont Idaho.	Sept 19 1930
20. Undertaker	**Address**
Cassedy Funeral Home	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72084

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15
161a

2. FULL NAME — new born. 6th mo. premature.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): new born —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Sept. 18-1930

7. AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) near Medimont

PARENTS
10. NAME OF FATHER Valance M. Beadle —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.
12. MAIDEN NAME OF MOTHER Edith B. Benner.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ventura Co. Cal.

14. Informant father
(Address) Medimont.

15. Filed Sept 18, 1930 H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Sept 18, 1930
that I last saw him alive on Sept 18, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Premature 6th month.

..... (duration) ..... yrs. about 15 mo mos. ..... ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of .....
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) H W Shryock, M. D.
Sept. 18, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Medimont. | Date of Burial: Sept. 19 1930

20. Undertaker: none | Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED SEP 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Latah

Primary Registration District No. 1011

File No. 72085

City of Moscow

(No. Inland Hospital St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Robert Thrift (adopted)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Child

6. DATE OF BIRTH: May 9 1930 (Month) (Day) (Year)

7. AGE: yrs. 3 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston, Ida.

10. NAME OF FATHER: James E. Thrift

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Lila Miller

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Thrift

(Address) Moscow, Idaho

15. Filed 9/25/30 191 J. Harry Erickson Local Registrar

MEDICAL CERTIFICATE OF DEATH. 118 B

16. DATE OF DEATH: Aug/ 26, 1930 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25th 1930, to Aug 25 1930 that I last saw him alive on Aug 25th 1930 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

Volvulus (Sigmoid)

(Duration) yrs. mos. 2 or 3 ds.

Contributory (Secondary) Toxemia - Shock.

(Duration) yrs. mos. 1 or 2 ds.

(Signed) C. H. Nagel M. D.

8/26 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 8/26/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72086

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Ann DeWitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: Aug. 12, 1874 (Month) (Day) (Year)

7. AGE: 56 yrs. ..... mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Williams Port, Indiana

10. NAME OF FATHER John W. Bush

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.C. DeWitt

(Address) Moscow

15. Filed 9/25/30 191 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH. 74

16. DATE OF DEATH: August 26, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1915, to Aug 26 1930, that I last saw her alive on Aug 10 1930, and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Epileptic Seizure from which she died before I could reach her

(Duration) all her life practically yrs. mos. ds.

Contributory (Secondary) Perhaps a weak heart

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.

8/27 1930 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 8/28/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow (rural)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72087

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Rich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child (Write the word.)

6. DATE OF BIRTH: August 25, 1930 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many 10 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Latah county, Idaho

10. NAME OF FATHER: Walter J. Rich

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ester Alice Germer

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Rich

(Address) Viola, Idaho

15. Filed 9/25/30 191 J. Hamp Einhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH. 162

16. DATE OF DEATH: August 25, 1930 (Month) (Day) (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Inanition

..... (Duration) ..... yrs. 9 mos. ..... ds.

Contributory (Secondary) Malformed cord.

..... (Duration) ..... yrs. 9 mos. ..... ds.

(Signed) [signature] M. D.

8/26 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viola cemetery

DATE OF BURIAL: 8/26/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED SEP 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow (rural)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72088

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otto Leaton Hylton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male ~~Male~~

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Child (Write the word.)

6. DATE OF BIRTH: August (Month) 21 (Day) 1930 (Year)

7. AGE: ..... yrs. ..... mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Child
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Near Moscow, Ida.

10. NAME OF FATHER Jewell Hylton

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Virginia Boone

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jewell Hylton

(Address) Moscow, Idaho

15. Filed 9/25 1930 J. Harry Emhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 162

Aug. 23, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21st 1930, to Aug. 23rd 1930, that I last saw him alive on Aug 23rd 1930 and that death occurred on the date stated above, at 10:P M.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Armstrong M. D.

8/25 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 8/25/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72089

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. Richards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (*Write* the word.)

6. DATE OF BIRTH: May 27 1874 (Month) (Day) (Year)

7. AGE: 56 yrs. 2 mos. 26 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Stockman
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Nordingdale Calif.

10. NAME OF FATHER John S. Richards

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Mary Woozley

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Richards

(Address) Moscow, Idaho

15. Filed 9/25/30 1930 J. Lawrence Einhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 5-8-3

August 23 1930 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...

and that death occurred on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Labial Ca c̄ extension to glands

Secondary Anaemia

..... (Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis, Progressive Asthenia

..... (Duration) ..... yrs. 2 mos. ..... ds.

(Signed) [signature] M. D.

8/23 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 8/24/30 191...

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12 RECEIVED SEP 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72090

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ELEANORE AGNES GALVIN

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH: July (Month) 4 (Day) 1861 (Year)

7. AGE: 69 yrs. 1 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School teacher
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Toledo Ohio

10. NAME OF FATHER: Michiel Chas. Galvin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen Ryan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Rose Galvin. C. S. U.

(Address) Moscow Idaho

15. Filed 9/25/30 1930 J. Harry Emhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH. 1013

16. DATE OF DEATH: Aug. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1930 191.., to Aug. 18 1930, that I last saw her alive on Aug. 18, 1930 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

8/18 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Toledo, Ohio

DATE OF BURIAL: ..... 191..

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72091

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Veele Wigen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Married (Write the word.)

6. DATE OF BIRTH: May 19 1852 (Month) (Day) (Year)

7. AGE: 78 yrs. 2 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Lars Veele

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Gertrude Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.J. Wigen

(Address) Moscow, Idaho

15. Filed Sept. 24 1930 J. Hans Einhorn Local Registrar

MEDICAL CERTIFICATE OF DEATH.

44

16. DATE OF DEATH: Aug. 17, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930 191, to Aug. 16, 1930 that I last saw her alive on Aug. 16, 1930 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gretman M. D.

8/19 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: La Crosse, Wn.

DATE OF BURIAL: 8/20/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED SEP 29 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 72092
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME RETTA HOLMAN

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
female	White	Widowed

6. DATE OF BIRTH: May (Month) 26 (Day) 1855 (Year)

7. AGE: 75 yrs. 2 mos. 10 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): DeMoines, Iowa

10. NAME OF FATHER: Delaney Colson

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: ; ; ;

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Holman
(Address) Moscow Idaho

15. Filed 9/24 1930 John Embree Local Registrar

MEDICAL CERTIFICATE OF DEATH. 44

16. DATE OF DEATH: Aug (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 29, to Aug 2 1930
that I last saw her alive on Aug 2 1930
and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:
Gastric Ca

(Duration) 3 yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis, Anaemia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roy Magee M. D.
Aug 6 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: 8/7/30 1930

20. UNDERTAKER: Roy M. Grim — ADDRESS: Moscow, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

RECEIVED SEP 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 72093

Registered No.

1. PLACE OF DEATH

County of LATAH

City of

(No. St.)

Registration District No. 65

Primary Registration District No. 2145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ANNA HOUGEN

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): WIDOWED

6. DATE OF BIRTH: APRIL (Month) 3 (Day) 1841 (Year)

7. AGE: 89 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): NORWAY

10. NAME OF FATHER: JOHNSON MOEN

11. BIRTHPLACE OF FATHER (State or Country): NORWAY

12. MAIDEN NAME OF MOTHER: UNKNOWN

13. BIRTHPLACE OF MOTHER (State or Country): NORWAY

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth M. Thompson (Daughter)

(Address) Harvard - Idaho

15. Filed July 1st 1930

D. J. H. Thompson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: JUNE (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from JUNE 28 1930 to JUNE 29 1930 that I last saw her alive on JUNE 29 1930, and that death occurred on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) Unknown Yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Hyden Hancher M. D.

6-30 1930 (Address) Potlatch - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Troy. DATE OF BURIAL: July 5th 1930

20. UNDERTAKER: E. Irwin. ADDRESS: Palouse Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72094

Registration District No. 6 5

Primary Registration District No. 2145

Local Registrar's No.

129

PLACE OF DEATH

County of Latah

City of Pottatch

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Fredrick Crathorne

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30 - 1853

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	10	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER G. Crathorne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Grace Rugg

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant P. G. Crathorne
(Address) Palouse Wash

15. Filed July 18th, 1930 Jos. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6th, 1930, to July 17th, 1930 that I last saw him alive on July 17th, 1930 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. Thompson, M. D.

July 18th, 1930 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash.	July 20 1930
20. Undertaker	Address
E. H. Irwin-Palouse	Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED SEP 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72095

PLACE OF DEATH
County of Latah
City of Pollaleth

Registration District No. 65
Primary Registration District No. 2145 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Oderlin

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 30 1853

7. AGE Years 76 Months 9 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER Not Known.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) Ethel G. Oderlin Seattle Wash.

15. Filed May 20th, 1930 509 Lord Bld. J. G. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on May 18, 1930, to —, 19—
that I last saw him alive on May 18, 1930
and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accidental - Chest
Crushed by a bull

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
— (duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) E. K. Wolfe, M. D.
May 20, 1930 (Address) Palouse Wn

19. Place of Burial, Cremation, or Removal Palouse Wash. Date of Burial May 21 1930

20. Undertaker E. H. Grimm Palouse Wash. Address

FORM V. S. No. 6-25 M. 1-19. RECEIVED SEP 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Pottatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 72096

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Balch.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Aug. (Month) 30 (Day) 1930 (Year)

7. AGE: ✓ Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none -

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pottatch

10. NAME OF FATHER: John L. Balch.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Aurora Mabel Rohlf.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mabel Balch.

(Address) Pottatch

15. Filed Sept 25 1930 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

162

16. DATE OF DEATH: Aug (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1930, to Aug 30 1930 that I last saw him alive on Aug 30 1930, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.

Sept 1 1930 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pottatch Cemetery

DATE OF BURIAL: Sept 1 1930

20. UNDERTAKER: Parents

ADDRESS: Pottatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72097

PLACE OF DEATH

County of Lath Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 52

(No. Inland Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melvin Monroe Preston 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mae Preston

6. DATE OF BIRTH (month, day and year): Jan. 16, 1865

7. AGE: Years 65, Months 9, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer): Machine Shops

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wis.

PARENTS

10. NAME OF FATHER: J.H. Preston

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: Sylvia Webster

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: E.C. Styner
(Address) Moscow, Ida.

15. Filed 10/9, 1930 Harry Einhorn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 28, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows: Heart disease - Coronary Thrombosis -

..... (duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes

..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. Magee, M. D.

9/30, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow — Date of Burial: 10-1-30 ~~9/30/30~~ 19

20. Undertaker: H. R. Short — Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

PLACE OF DEATH

County of Latah

City of Moscow (rural)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 10 11

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72098

Local Registrar's No. 51

131

2. FULL NAME Harriett Phoebe Jordan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of G.W. Jordan

6. DATE OF BIRTH (month, day and year) March 1, 1866

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	6	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER James Woods

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Margaret Daughtery

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant J.F. Jordan

(Address) Moscow, Idaho

15. Filed 10/9, 30 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 26, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May, 1930, to Sept 26, 1930 that I last saw her alive on Sept 26, 1930 and that death occurred, on the date stated above, at 10 00 m.

The CAUSE OF DEATH* was as follows:

Brights Disease

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) W.A. Adair, M. D.

9/29, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Viola cemetery	9/29/30 19

20. Undertaker	Address
F.K. Stout	Moscow

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72099

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 6-1
Primary Registration District No. 1-01
(No.)
Local Registrar's No. 50

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ABRAHAM NORRIS 90

(a) Residence. No. Viola (Usual place of abode) Wash St. (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Norris

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carol Co. Ind.

PARENTS

10. NAME OF FATHER Ellis Norris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Elizabeth Cooper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dayton Ohio

14. Informant Mrs Abraham Norris
(Address) Viola Idaho

15. Filed 10/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 24 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Sept 23, 1930 to , 19 ; that I last saw him alive on Sept 23, 1930 and that death occurred, on the date stated above, at 6:45am m.

The CAUSE OF DEATH* was as follows:
Heart Disease - Mitral disease & failure of Compensation
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Congestion - Nephritis
(duration) yrs. mos. None ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys Examination
(Signed) [signature], M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal		Date of Burial
Viola	Ida	9/26/30

20. Undertaker R. M. Grim — Address Moscow, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[redacted]

PLACE [redacted]

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72100

Local Registrar's No. 49

58a

2. FULL NAME Miss CARRIE A. BROWN

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
67	0	10	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hillsborough Ohio

PARENTS

10. NAME OF FATHER Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Homer E Estes

(Address) Moscow Idaho

15. Filed 10/9, 1930 J. Harry Enhouse Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 21 (Day), 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to Sept. 21, 1930

that I last saw her alive on Sept. 20, 1930, 19

and that death occurred, on the date stated above, at 6:15 am m.

The CAUSE OF DEATH* was as follows:

Anemia & Starvation.

..... (duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma Gastric.

..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? X Ray & Clinical

(Signed) J. Harry Enhouse, M. D.

9/22, 1930 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burial Moscow Ida	9/23/30

20. Undertaker	Address
R. M. Grim	Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72101

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011

Local Registrar's No. 48

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME INA LAURA PITT

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
30	9	11	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School teacher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Albion Wash

PARENTS

10. NAME OF FATHER: Louis R. Pitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Chio
12. MAIDEN NAME OF MOTHER: Pearl Dash
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kansas

14. Informant: Mrs Louis Pitt
(Address): Moscow Idaho

15. Filed 10/9, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1929, to Sept 19, 1930
that I last saw h[er] alive on Sept 19, 1930
and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Microscopic.
(Signed) C. A. Armstrong M. D.
9/22, 1930 (Address) Moscow Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burial VICLA, Ida	9/22/30

20. Undertaker	Address
R. M. Grim	Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72102

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

126

2. FULL NAME DELLA VICTORIA (GREEN) CROWE

(a) Residence. No. ..... St. Grangeville Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Alton Crowe

6. DATE OF BIRTH (month, day and year)

7. AGE: 27 Years | Months: 2 | Days: 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Moscow Idaho

PARENTS

10. NAME OF FATHER: Carl Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweeden
12. MAIDEN NAME OF MOTHER: Ida Lundquist
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn.

14. Informant: Alton Crowe
(Address) Grangeville Idaho.

15. Filed 10/9, 1930. J. Harry Enhouse, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 19, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 19-, 1930
that I last saw her alive on Sept 19, 1930
and that death occurred, on the date stated above, at 7:45 A m.
The CAUSE OF DEATH* was as follows:

Peritonitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Hernia operation

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Sept 13-30
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Chas. L. Gritman, M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow | Date of Burial: 9/21/30

20. Undertaker: R. M. Grim | Address: Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72103

Local Registrar's No. 46

480

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 6 1

Primary Registration District No. 1 0 1 1

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ELLEN JANE CHRISTY

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dr Alexander Christy

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	71	2	1	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mansfield, Ohio

PARENTS

10. NAME OF FATHER George Blackburn

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jane Lamberton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs Ethel Batterson
(Address) Moscow Idaho

15. Filed 10/9, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) I9, I930 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1930, to July 28, 1930
that I last saw her alive on July 28, 1930
and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Endocarditis- Chronic.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. L. Gilmore M. D.

9/20/30, 19..... (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or~~ Removal	Date of Burial
St. Maries, Ida.	9/22/30
20. Undertaker	Address
R. M. Grimm	Moscow, Ida

RECEIVED OCT 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)

File No. 44 72105
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Jane Brouillet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 21 (Day) 1840 (Year)

7. AGE: 90 yrs. 6 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Misouri

10. NAME OF FATHER: James P. Angell[illegible]

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarena Hill

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W. W. Markham
(Address) Moscow Idaho

15. Filed 10/7 1930 J. Hamilton Erskine
Local Registrar

MEDICAL CERTIFICATE OF DEATH. 90

16. DATE OF DEATH: Sept (Month) 18, (Day) 1930 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from July 4th 1930, to Sep. 18 1930, that I last saw her alive on Sep 14 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
~~[illegible]~~
aortic insufficiency

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) arteriosclerosis.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Pittman M. D.
9-18-1930 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Colville, Wash
DATE OF BURIAL: 9/20/30 191

20. UNDERTAKER: R. M. Grim
ADDRESS: Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED OCT 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. 309 S. Polk St.)

File No. 43 72106

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Franklin Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (*Write* the word.)

6. DATE OF BIRTH: May 7 (Month) (Day) 1877 ~~1833~~ (Year)

7. AGE: 53 yrs. 4 mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Poultryman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Samsvalley, Oregon

10. NAME OF FATHER: John F. Cox

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Rowe

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Bud Adair

(Address) Patlatch, Ida.

15. Filed 10/9 1930 J. Harry Einhorn Local Registrar

MEDICAL CERTIFICATE OF DEATH. 44a

16. DATE OF DEATH: Sept. 10, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from on Sept. 10, 1930 only 191 , that I last saw him alive on Sept 10 1930. and that death occurred on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis and Myocarditis.

(Duration) 3 yrs. mos. ds.

Contributory (Secondary) Arthritis Rheumatic

(Duration) 7 yrs. mos. ds.

(Signed) J. Harry Einhorn M. D.

9/11 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Freeze cemetery

DATE OF BURIAL: 9/13/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED OCT 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of ~~#####~~ Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. Inland Hospital St.)

File No. 472107

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widowed (Write the word.)

6. DATE OF BIRTH: October 9 1849 (Month) (Day) (Year)

7. AGE: 80 yrs. 10 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Harry Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss. Mabel Johnson

(Address) Moscow, Idaho

15.

Filed 10/9 1930 J. Sam Einhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 8, 1930 (Month) (Day) 1889 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1930, to Sept 7 1930, that I last saw him alive on Sept 7 1930, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
(1) (R) foot crushed off by falling safe
(2) Fracture of Right Femur c̄ injury to Ileum c̄ Internal injury causing
(3) obstruction of bowel (Duration) yrs. mos. 10 ds.

Contributory (Secondary) Age & altho I never saw this man by professionally I believe there was a lesion of stomach (Duration) yrs. some mos. ds.

(Signed) [signature] M. D.

9/10 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Moscow

DATE OF BURIAL: 9/10/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

RECEIVED OCT 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 47218

Registered No.

1. PLACE OF DEATH.

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. Gritman Hospital St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Granvel Walden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Sept. 10 (Month) (Day) 1930 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 12 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Moscow, Ida.

10. NAME OF FATHER: James J. Walden

11. BIRTHPLACE OF FATHER (State or Country): Carelton, Mo.

12. MAIDEN NAME OF MOTHER: Bernice Hagen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Walden

(Address) Moscow, Idaho

15. Filed 10/9 1930 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. 10/ (Month) (Day) 1930 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1930 to Sept. 10 1930, that I last saw him alive on Sept. 10 1930, and that death occurred on the date stated above, at 2:25 P.M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Severe nephritis of mother.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

9/11 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 9/12/30 191

20. UNDERTAKER: F. R. Short — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 19760

RECEIVED OCT 14 1930

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 61

County of Latah

Primary Registration District No. 1011

City of Moscow (No. ....., ... St.)

File No. 72109

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dona Iliene Stevens

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Nov. 7 (Month) (Day) 1925 (Year)

7. AGE: 4 yrs. 9 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Idaho

10. NAME OF FATHER: Francis E. Stevens

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Eva Keeler

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F.E. Stevens
(Address) Moscow, Idaho

15. Filed 10/9/30 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

114

16. DATE OF DEATH: Sept. 4, / 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1930, to Sept 4 1930, that I last saw her alive on Sept 4 1930 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Toxemia + Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) E.R. Magee M. D.

9/5 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	9/6/30 191

20. UNDERTAKER H.R. Short — ADDRESS Moscow

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 20 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 47

County of Lewis — Primary Registration District No.

City of Nezperce Idaho (No. ..... St.)

File No. 153

Registered No. 12117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Tibbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY. PERMANENT RECORD.
N. B.—Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION and instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Tibbs

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George W Lewis
(Address) Lewiston Idaho

15. Filed Sept 14 1930 Albert Kaff Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

120

16. DATE OF DEATH About [redacted] (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicide, shot himself with
25-20 Winchester rifle
probably was dead 10 days or more
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... ds.
(Signed) [redacted] M. D.
19... (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery — DATE OF BURIAL: May 27 1930

20. UNDERTAKER: Albert Kaff — ADDRESS: Nezperce Idaho

RECEIVED SEP 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72111

PLACE OF DEATH

County of Lewis
City of Nezperce Idaho
Russel vicinity

CERTIFICATE OF DEATH

Registration District No. 47
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 151

2. FULL NAME Electa Campbell

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

133

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day and year)

7 AGE: 60 Years; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Getaway Ohio

PARENTS
10 NAME OF FATHER: Elisha Thacker
11 BIRTHPLACE OF FATHER (city or town) (State or country): West Virginia
12 MAIDEN NAME OF MOTHER: Josephine Nowlin
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Elmer Campbell
(Address) Orofino Ida #1

15 Filed Sept 11 1930 Albert Huff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 4 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to April 2, 1930 that I last saw her alive on March 15, 1930, and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:
Gall bladder disease
(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Starvation
(duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Non
(Signed) A. B. Pappenhagen, M. D.
April 4, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Gilbert Idaho
Date of Burial: April 7 1930

20. Undertaker: Albert Huff
Address: Nezperce Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED SEP 20 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Nezperce Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47

Primary Registration District No.

(No. ....., ... St.)

File No. 72112

Registered No. 152

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Newton Seehorn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1863 (Year)

7. AGE 67 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farming

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER James Seehorn

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER ✓ McRoberts

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Louise Seehorn

(Address) Mohler Idaho

15. Filed Sept 11 1930 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH May (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Long Illness Heart failure. dropped dead

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Albert Huff Coroner M. D.

..... 19..... (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery

DATE OF BURIAL: May 23 1930

20. UNDERTAKER: Albert Huff

ADDRESS: Nezperce Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72113

PLACE OF DEATH

County of Lewis Registration District No. 60

City of Westlake (or) Primary Registration District No. 2129

Local Registrar's No. 17

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Alonzo Patterson Crews

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Medora Crews

6. DATE OF BIRTH (month, day and year) Feb 18 1852

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER James Patterson Crews

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Isabel Gardner

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant J A Crews
(Address) Westlake Ida

15. Filed 9/13 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1922 to Sept 13, 1930
that I last saw h[illegible] alive on Sept 9 1930
and that death occurred, on the date stated above, at 6 05 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
(duration) — yrs. mos. 3½ ds.
CONTRIBUTORY (Secondary) myocardial endocarditis
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? urine
(Signed) R E Durant M. D.
9/13, 1930 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I O O F Cemetery Craigmont Ida	9-15 1930
20. Undertaker Craigmont Hdwe Co	Address Craigmont

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7211

Registration District No.
Primary Registration District No.
Local Registrar's No. 19

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

PLACE OF DEATH
County of Lincoln
City of Dietrich

2. **FULL NAME** Jas W Myers

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Flora Myers

6. DATE OF BIRTH (month, day and year) March 15 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	6	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Wm Myers
~~Unknown~~

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
~~Unknown~~

12. MAIDEN NAME OF MOTHER Amy Pitt
~~Unknown~~

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Frank Myers
(Address)

15. Filed Sept 24 1930 J. A. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to Sept 17, 1930
that I last saw h~~im~~ alive on Sept 17, 1930
and that death occurred, on the date stated above, at 12.30 ~~P~~ m.

The CAUSE OF DEATH* was as follows:
Chronic Hypocarditis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial Nephritis
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam.
(Signed) J. E. Bassett, M. D.
Sept 22, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	9-23 1930
20. Undertaker	**Address**
C E Hickok	Shoshone Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 11 1930

PLACE OF DEATH

County of Lincoln

City of Richfield

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 2016

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72115

Local Registrar's No. 20

74a

2. FULL NAME Andrew C. Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Peterson

6. DATE OF BIRTH (month, day and year) Feby 10th 1871

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	7	24	

8. OCCUPATION OF DECEASED Retail Merchant
(a) Trade, profession, or particular kind of work ~~Mgr. General Store~~
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Scandia
(State or country) Minn

PARENTS

10. NAME OF FATHER Gusta Peterson

11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER ~~Caroline~~ Unknown

13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Mary Peterson
(Address)

15. Filed Oct 7, 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-4-, 1930, to 10-4-, 1930
that I last saw him alive on 10-4-, 1930
and that death occurred, on the date stated above, at 5130P m.
The CAUSE OF DEATH* was as follows: apoplexy

..... (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) W. H. Bangs M.D.
10-5-, 1930 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Idaho
Date of Burial: Oct 7 1930

20. Undertaker: C. E. Hickok
Address: Shoshone Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ...
TION is very important. See instruction on back of certificate.

RECEIVED OCT 11 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72116

1. PLACE OF DEATH

County Lincoln State IDAHO Registered No. 21

Township _____ or Village Shoshone or

City Shoshone No. _____ St., _____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Delilah Saviers

164

(a) Residence: No. _____ St., _____ Ward. _____

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Widowed John W. Saviers

6. DATE OF BIRTH (month, day, and year) Feb. 9. 1849

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
~~8X~~	81	7	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own Home

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Winterset (State or country) Ohio

FATHER

13. NAME Samuel A Todd

14. BIRTHPLACE (city or town) Kentucky (State or country)

MOTHER

15. MAIDEN NAME Letitia B Booth

16. BIRTHPLACE (city or town) Ohio (State or country)

17. INFORMANT S. E. Todd (Address) Shoshone Idaho

18. BURIAL, CREMATION, OR REMOVAL Place Shoshone, Idaho Date Oct 8th, 1930

19. UNDERTAKER C E Hickok (Address)

20. FILED Oct 8, 1930 J. L. Fuller Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Oct 7, 1930

22. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930 to Oct 7, 1930

I last saw her alive on Oct 7, 1930; death is said to have occurred on the date stated above, at 8:40 a.m.

The principal cause of death and related causes of importance were as follows:

Senility

Date of onset

Other contributory causes of importance:

Name of operation — Date of —

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) [signature], M. D.

(Address) _____

c11—3184

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—2091
V. S. No. 98

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7211

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 218
Local Registrar's No. 51

(No.) 480
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Woodrow Floyd Fowler

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 5th 1914

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work On the Farm With
(b) General nature of industry, business, or establishment in which employed (or employer) his father and
(c) Name of employer at School.

9. BIRTHPLACE (city or town) (State or country) Taber Alberta Canada

PARENTS

10. NAME OF FATHER J. H. Fowler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Bertha L. Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Willard Utah

14. Informant J. H. Fowler
(Address) St Anthony # 3.

15. Filed Oct 16, 1930 J. Bingham Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1st, 1930, to Oct 4, 1930
that I last saw him alive on Oct 4, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis
Following
(1) Pneumonia
(2) Enteritis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? yes, Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) A. E. King, M. D.
Oct 6, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parker Ida.	Oct 8th 1930
20. Undertaker	Address
Vern J. Keller	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72118

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2[illegible]
Local Registrar's No. [illegible]

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mary Christina Neeley.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of William Neeley.

6. DATE OF BIRTH (month, day and year) June 7, 1842

7. AGE: Years 88, Months 3, Days 26. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark. Sheland.

PARENTS

10. NAME OF FATHER Nels. H Nelson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark. Sheland.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant John M. Neeley
(Address) Rexburg Ida.

15. Filed 10/6, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1930, to Oct. 4, 1930
that I last saw him alive on Oct. 4, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Senility Dementia)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Age & Mental Condition
(Signed) H B Rigby, M. D.
Oct. 6, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brigham Utah. Date of Burial: Oct 7 1930

20. Undertaker: Vern J Keller Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72119

PLACE OF DEATH

County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

18B

2. FULL NAME Mary Ann Smith.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed.

5a. If married, widowed, or divorced ~~HUSBAND~~ of ~~(or)~~ WIFE of Albert Smith.

6. DATE OF BIRTH (month, day and year) June 19 - 1870.

7. AGE Years 60 Months 3 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER George A Humble
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Olive Cheney.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Ray. Westover
(Address) Rexburg, Ida.

15. Filed 10/3, 1930 J. Wyoming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1925, to Sept. 28, 1930
that I last saw her alive on Sept. 28, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Decompensation)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) A. B. Rigby, M. D.
Oct 3, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Victor. Idaho. Date of Burial Oct. 3 1930.

20. Undertaker Vern J Keller Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72139

PLACE OF DEATH
County of Bonneville
City of Swan Valley

Registration District No. 100
Primary Registration District No. 2178
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 47

201

2. FULL NAME Vernal Glen Cherry

(a) Residence. No. Rexburg Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	7	25	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer / Farm
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Russel Farms

9. BIRTHPLACE (city or town) (State or country) Salem Idaho

PARENTS

10. NAME OF FATHER Delonzo Cherry

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Almina Judy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Almina Cherry
(Address) Rexburg Idaho

15. Filed 9/29, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Sept 28, 1930
that I last saw h. alive on Sept 1- 1930
and that death occurred, on the date stated above, at 4 PM m.
The CAUSE OF DEATH* was as follows:
Fractures of Skull
Numerous broken bones
(accidental) (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) fall over 450 ft cliff.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Swan Valley Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Lorin L. Rich. M. D.
9-29-, 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Removed by sheriff of Bonneville County

19. Place of Burial, Cremation, or Removal: Rexburg Cemetery — Date of Burial: 10/1 1930

20. Undertaker: Russel Adams — Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7212

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 10
Primary Registration District No. 214

Local Registrar's No. 4

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

114

2. FULL NAME Janice Garner.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 11, 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3.	3	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Ida.

PARENTS

10. NAME OF FATHER Walter Garner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Teton Ida
12. MAIDEN NAME OF MOTHER Rilla Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Franklin Ida.

14. Informant Walter Garner
(Address) Rexburg

15. Filed Nov 22, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 22nd 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930, to Sept. 22, 1930
that I last saw her alive on Sept. 22, 1930
and that death occurred, on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Acute enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. Sutherland, M.D.
9-22, 1930 (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Ida.	Sept 25 1930
20. Undertaker	Address
Geo. J. Kelly	Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72122

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2,18
Local Registrar's No. 45
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Harold Ellis Madden

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Madden

6. DATE OF BIRTH (month, day and year)

7. AGE 50 Years | Months | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sharon Penn.

PARENTS

10. NAME OF FATHER Philip Madden
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown (Ellis)
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs Madden
(Address) Rexburg Idaho

15. Filed 9/24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... (Month) ..... (Day) ..... 19.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Aortic Aneurism
Rupture of
about (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? X-ray
(Signed) H B Rigby, M. D.
Sept 24, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg Cemetery
Date of Burial: 9/24 1930

20. Undertaker: Russel R. Flamm
Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72183

PLACE OF DEATH
County of Madison
City of Plano

Registration District No. 101
Primary Registration District No. 2028
Local Registrar's No. 44

(No. 101 B)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Davis Hemsley

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 20th-1865

7. AGE Years	Months	Days	If LESS than 1 day,
65	8	11	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John F. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Ellis Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant James J. Hemsley
(Address) Rexburg-Idaho

15. Filed 9/1, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Sept. 1, 1930
that I last saw h er alive on Sept 1, 1930
and that death occurred, on the date stated above, at 12:30 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) Pleurisy
(duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) [signature], M. D.
9-1, 1930 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Plano Ida	Sept 4 1930
20. Undertaker	Address
Wm J Keller	Rexburg

RECEIVED OCT 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72124

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 49
(No.) 107
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Hegsted
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 9th 1875

7. AGE Years 55 Months 7 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming And County
(b) General nature of industry, business, or establishment in which employed (or employer) Auditor,
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Huntsville Utah

PARENTS
10. NAME OF FATHER H C S Hegsted
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Christena Olsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs John Hegsted
(Address) Rexburg, Idaho

15. Filed 9/28, 1930 J Rexburg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1926, to Sept 26, 1930
that I last saw VM alive on Sept 20, 1930
and that death occurred, on the date stated above, at 9.45 A. m.
The CAUSE OF DEATH* was as follows:
Respiratory collapse
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Bulbar paralysis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Lorin F. Rich, M. D.
9-28, 1930 (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg Ida
Date of Burial Sept, 30 1930

20. Undertaker Vern J. Keller
Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72125

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 351

PLACE OF DEATH
County of Madison
City of Plano
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Swan

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 27-1869

7. AGE: Years 60 | Months 9 | Days 28 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Stock Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dequoin Ill

PARENTS
10. NAME OF FATHER: Robert Swan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah Schofield
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Mrs Florence Hancock
(Address): Black Diamond Wash

15. Filed Sept 24, 1930 W.M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 21, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Died Very Suddenly, before Physician could be called
Acute Myocardial Failure (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? County Coroner
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. M. Hansen, M. D.
Sept 24, 1930 (Address) St. Anthony Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview | Date of Burial: Sept. 25 1930

20. Undertaker: W. M. Hansen | Address: St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FRACTIONS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72126

PLACE OF DEATH

County of Fremont

City of Wilford

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 350

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Elvin B Stewart

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 29th 1915

7. AGE

Years	Months	Days	If LESS than 1 day,
14	11	23	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ida,

PARENTS

10. NAME OF FATHER Ben Stewart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Caroline Birch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Ben Stewart
(Address) Wilford Idaho,

15. Filed Sept. 22, 1930 W M Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930, to Sept. 21, 1930
that I last saw him alive on Sept. 21, 1930
and that death occurred, on the date stated above, at 10.30 a.m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. M. Kelly, M. D.

Sept. 21, 1930 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford Idaho

Date of Burial: Sept 23 1930

20. Undertaker: Vern J. Keller

Address: Rexburg Ida.

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72127

PLACE OF DEATH
County of Minidoka
City of Heyburn

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Affalona Angelina Heiner. 90
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Heiner
6. DATE OF BIRTH (month, day and year) Sept 21 1868
7. AGE Years 62 Months Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Echo Canyon Summit Co.

PARENTS
10. NAME OF FATHER Roswell Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Mary Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Anthony Heiner Heyburn Ida

15. Filed 10-4, 1930 E H Elmore Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 22, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Sept 22, 1930
that I last saw her alive on Sept 22, 1930
and that death occurred, on the date stated above, at 3:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
(duration) about 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Toxic Goiter
(duration) about 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Lelon Frazier, M. D.
, 19 (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal Heyburn Id. Date of Burial Sept. 25 193
20. Undertaker W. E. Johnson Address Burley

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72128

PLACE OF DEATH

County of ~~Lewis~~ Nez Perce
City of Melrose
Registration District No. 92
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

21

2. FULL NAME Donold George Lundvall

(a) Residence. No. Melrose, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 5, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	One	Thirteen	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Melrose, Idaho
(State or country)

PARENTS

10. NAME OF FATHER George Ernest Lundvall

11. BIRTHPLACE OF FATHER (city or town) Albany, Calf.
(State or Country)

12. MAIDEN NAME OF MOTHER Violet Bacon

13. BIRTHPLACE OF MOTHER (city or town) Melrose Idaho
(State or Country)

14. Informant C E Bacon
(Address) Melrose, Idaho

15. Filed , 19 E. E. Datts
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 18, 1930
that I last saw him alive on Sept. 18, 1930
and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:
Erysipelas of head and neck.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. one ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam.

(Signed) A. B. Halliday, M. D.
9—18, 1930 (Address) Winchester, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Melrose Idaho	Sept 20 1930
20. Undertaker C. A. Butler	Address Melrose Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72130

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township ____ or Village Sweetwater or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Henry Taboboo

(a) Residence. No. ____ Sweetwater St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1929

7 AGE

Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
1	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sweetwater
(State or country) Idaho

PARENTS

10 NAME OF FATHER John Taboboo

11 BIRTHPLACE OF FATHER (city or town) Sweetwater
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Elizabeth Broncho

13 BIRTHPLACE OF MOTHER (city or town) Cuddeson
(State or country) Idaho

14 Informant George Gaignard M.D.
(Address) Cuddeson, Ida.

15 Filed 9/3/, 1930 L.M. Maxwell REGISTRAR

11—2184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1930

17 I HEREBY CERTIFY, That I attended deceased from
7-1-, 1930, to 7-19-, 1930,
that I last saw him alive on 7-19-, 1930,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Pertussis

____ (duration) 6 yrs. ____ mos. 19 ds.
CONTRIBUTORY (SECONDARY) Broncho-pneumonia
____ (duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted
if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) George Gaignard, M. D.
19 (Address) Cuddeson, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Slickpoo Cemetery	7-20-1930
20 UNDERTAKER	ADDRESS
Brower-Kenworthy Co	Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—20 d
V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72131

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Spalding or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

RECEIVED SEP 11 1930

2 FULL NAME Billy Davis

87

(a) Residence. No. Spalding St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Davis

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 79 | Months — | Days — | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): Invalid
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Nez Perce Reservation Idaho

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): "
12 MAIDEN NAME OF MOTHER: "
13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Sophia D. Broncke
(Address) Spalding

15 Filed 7/15, 1930 L. Maxwell
REGISTRAR

11—6184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Rheumatism

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Pericarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) ....., M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Cemetery
DATE OF BURIAL: July 15 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72133

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 16
Primary Registration District No. 1009
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44B

2. FULL NAME Joseph Jabbora
(a) Residence, No. St. Moscow Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 30 - 1917

7. AGE Years 12 Months 11 Days 16 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Thomas Jabbora
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Syria
12. MAIDEN NAME OF MOTHER Effie Junke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant Joseph Jabbora
(Address) Moscow Ida

15. Filed 10, 1930 J. M. Lyle By NB Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept 16th, 1930
that I last saw him alive on Sept 16th, 1930
and that death occurred, on the date stated above, at 2 9 m.
The CAUSE OF DEATH* was as follows:

Chr Myocarditis
(duration) + yrs. mos. ds.
CONTRIBUTORY (Secondary) Chr Interstitial Nephritis
(duration) + yrs. mos. ds.

18. Where was disease contracted if not at place of death? Orofino Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam & Laboratory tests
(Signed) O C Carsow, M. D.
, 19 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moscow Ida
Date of Burial 19

20. Undertaker Vassar Mortuary
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72134

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 76

Primary Registration District No. 1009

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

71B

2. FULL NAME Wilbur Dean Mathews.

(a) Residence. No. ..... St. Kooskia, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 23rd, 1930.

7. AGE: Years X; Months -6-; Days -7-; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kooskia, Idaho.
(State or country) Idaho.

PARENTS

10. NAME OF FATHER William Mathews.

11. BIRTHPLACE OF FATHER (city or town) Arkansas.
(State or Country)

12. MAIDEN NAME OF MOTHER Mabel Westman.

13. BIRTHPLACE OF MOTHER (city or town) Moscow, Idaho.
(State or Country)

14. Informant
(Address) Kooskia, Idaho.

15. Filed 10-1, 1930 J. M. Lyle By N.B. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 30th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to Sept 30, 1930
that I last saw ~~him~~ alive on Sept 27, 1930
and that death occurred, on the date stated above, at 12:45 a.m.
The CAUSE OF DEATH* was as follows:
Cerebrospinal Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ilio Colitis

(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death? Kooskia Ida

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L B Stockslager, M. D.

9/30/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia, Idaho. Date of Burial 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72135

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1059
(No. Nitz Hospital)
Local Registrar's No. 134
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Bert Whitcomb

(a) Residence. No. 411 Adams St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Bert Whitcomb

6. DATE OF BIRTH (month, day and year): Nov 2 1891

7. AGE: Years 38 | Months 8 | Days 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dallas Ore

PARENTS

10. NAME OF FATHER: C V. Cavin
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Martha M-Merlin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: B F Whitcomb
(Address): Lewiston Idaho

15. Filed 10-1, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 15, 1930, that I last saw her alive on July 15, 1930, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Post operative Shock
14 Hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic-hepatic-Anoxy
Chronic Hyp. complicating Salpingitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of 7-15-30

Was there an autopsy? No

What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. Whitt, M. D.

7-16, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston — Date of Burial: July 17 1930

20. Undertaker: Vassar Mortuary — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72136

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No.
(No.)
Local Registrar's No. 196

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Taylor

(a) Residence. No. St. Culdesac Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary L. Taylor

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 45 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Highway
(c) Name of employer State of Idaho.

9. BIRTHPLACE (city or town) (State or country) Omaha Nebr.

PARENTS

10. NAME OF FATHER Benj Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Manchester Iowa
12. MAIDEN NAME OF MOTHER Elizabeth Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Mary L Taylor
(Address) Culdesac Idaho

15. Filed Sept 5, 1930 M. Fyfe Registrar
By MB

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-2-30, 19 to 8-2-30, 19
that I last saw h[illegible] alive on 8-2-30, 19
and that death occurred, on the date stated above, at 330 p. m.
The CAUSE OF DEATH* was as follows:
Crushed chest caught in a cave in of gravel bank.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms.

(Signed) H. Rourke M. D.
9-5-30, 19 (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	8/5 1930
20. Undertaker	Address
Brown-Mann Co	Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72136

PLACE OF DEATH

County of Nezperce
City of Lewiston,

Registration District No. 66
Primary Registration District No. 1009
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1180

2. FULL NAME Ida M Clark

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Clark

6. DATE OF BIRTH (month, day and year) January 18, 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	7	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Umatilla Co. Oregon

PARENTS

10. NAME OF FATHER John A Richardson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Susanna Harrington

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant Lewis Clark (Husband)
(Address) Clarkston, Wash.

15. Filed 9-3-30, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Sept 1, 1930
that I last saw her alive on Sept 1, 1930
and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:
Strangulated ventral hernia (throughout operation scar)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Clarkston wash
Did an operation precede death? yes Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Paul B Johnson, M D.
Sept 3, 1930 (Address) Lewiston Ida Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Juliaetta, Ida. — Date of Burial: 9/4/30 19

20. Undertaker: H. R. Merchant — Address: Clarkston Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72139

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Mrs. Marie Andersen

(a) Residence. No. 1318-F St. Orofino Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) August 4, 1861

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): ~~Norway~~ Denmark

PARENTS

10. NAME OF FATHER: Thompson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: ~~M. E. Moore~~ Fred D Hammond

(Address) ~~1318-F St.~~ Orofino

15. Filed 10-1, 1930 J M Kyle By NB Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~August~~ ~~August~~ Sep 6 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 1926, to Sep 6, 1930

that I last saw her alive on Sep 5 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma. Primary carcinoma of left breast. Op. 4 yrs ago. (metastases in liver and retro peritoneal glands) 4 yrs. mos. ds. (duration)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Orofino Idaho

Did an operation precede death? yes Date of 1926

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul W Johnson M. D.

Sep 7, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial~~, ~~Cremation~~, or Removal: Orofino Idaho

Date of Burial: 9/8 1930

20. Undertaker: VASSAR MORTUARY

Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72140

PLACE OF DEATH
County of Ney Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

48 B

2. FULL NAME Rosella M Willoughby

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4th 1848

7. AGE Years 81 Months 11 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Thos. Willoughby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Adaline Mary Lindsey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant P. B. Willoughby
(Address) Lewiston

15. Filed 10-1, 1930. J. M. Lyle Registrar
By N. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1930, to Sept 6th, 1930 that I last saw her alive on Sept 6th, 1930 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
9-7, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial Sept 7 1930

20. Undertaker Vassar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72141

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph's Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Dora Ann Florence

(a) Residence. No. 714-3d St. Clarkston, Wash St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 23, 1892

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	4	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: school teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Davenport, Wash.

PARENTS

10. NAME OF FATHER: Valenna V. Florence

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Rachael F. Kennedy

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: Alta Florence

(Address) 714-3d St. Clarkston, Wash

15. Filed 10 1, 1930. J. M. Lyle Registrar
By N. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to Sept 7, 1930

that I last saw her alive on Sept 7, 1930

and that death occurred, on the date stated above, at 145 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Auscorbis Wash

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E G Broadock, M. D.

Sept 9, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clarkston Wash

Date of Burial: 8/9 1930

20. Undertaker: H R Merchant

Address: Clarkston Wash

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72142

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Augustus Farrington.

(a) Residence. No. St. Southwick, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12th, 1892.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38.	2.	1.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Saw mill owner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gold Hill, Idaho.

PARENTS

10. NAME OF FATHER Frank L. Farrington.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.
12. MAIDEN NAME OF MOTHER Edith Berryman.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Mrs. Gus Farrington
(Address) Southwick, Idaho.

15. Filed 9-15-1930 J.M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 13th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Sept 13, 1930
that I last saw h~~im~~ alive on Sept 13, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Septic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W O Clark, M. D.
9/15/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gold Hill, Idaho.	9/16/30. 19
20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72143

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

44

2. FULL NAME Ira Walker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Negro
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE About Years 58 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant —
(Address)

15. Filed 10-1, 1930 J. M. Lyle Registrar By N.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 16th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Sept 16, 1930
that I last saw him alive on Sept 16, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Carcinoma of liver - gall bladder + pyloric end of stomach
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Unknown
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White M. D.
9-26, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston
Date of Burial 9/19 1930

20. Undertaker Vassar Mortuary
Address Lewiston

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72144

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. Whites Hospital)
Local Registrar's No. 9610
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bertha Mae Anderson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 18th 1930

7. AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Frank Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Leona Waychoff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Frank Anderson
(Address) Clarkston Wn

15. Filed 10-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 18th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18, 1930, to Sept 18, 1930
that I last saw her alive on Sept 18, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Premature birth 6½ months.
..... (duration) ..... yrs. ..... mos. 2 hours ds.
CONTRIBUTORY (Secondary) Unknown.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms.
(Signed) E. L. White, M. D.
....., 19..... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	9/19 1930
20. Undertaker	**Address**
Vassar Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Lyle

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72145

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1909
(No. St. Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James C Jones
(a) Residence No. Southwick Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20th 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	4	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook.
(b) General nature of industry, business, or establishment in which employed (or employer) Camp & Hotel Cook.
(c) Name of employer not employed for some time

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER G W. Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Eliza Buscol
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant G W Jones
(Address) Southwick Ida

15. Filed 9-23-30 J M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9 1930 to Sept 23 1930
that I last saw him alive on Sept. 22 1930
and that death occurred, on the date stated above, at 12-30 m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Peritoneum
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Yes Date of May 1930
Was there an autopsy? Yes
What test confirmed diagnosis? Physical signs
(Signed) J. M. Lyle, M. D.
9-23, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Southwick	Sept 24 1930
20. Undertaker Vassar Mortuary Inc	Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72146

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph Hospital)
Local Registrar's No. 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joshua Kline

(a) Residence. No. N. Lewiston St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Persis A. Kline

6. DATE OF BIRTH (month, day and year) May 20 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	4	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Loading Lumber etc
(c) Name of employer Clearwater Timber Co.

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10. NAME OF FATHER James Kline

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Virginia

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs J. Kline
(Address) N. Lewiston Idaho

15. Filed 10-1, 1930 J. M. Lyle Registrar
By Mrs

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 24, 1930
that I last saw him alive on Sept 23, 1930
and that death occurred, on the date stated above, at 12:15 A m.
The CAUSE OF DEATH* was as follows:

Angina Pectaris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none

(Signed) E. E. Brandreth, M. D.
Sept 24, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston Idaho	
20. Undertaker	Address
Vassar Mortuary	Lewiston

Caisson

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72147

PLACE OF DEATH
County of Ney Perce
City of Lewiston

Registration District No. 96
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Elton Squires
(a) Residence. No. 205 - 11st St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 15 - 1879

7. AGE Years 51 Months — Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER Hazen Squires
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New Hampshire
12. MAIDEN NAME OF MOTHER Louise Beck
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) California

14. Informant Mrs Elton Squires
(Address) Lewiston Ida

15. Filed 10-1, 1930 J. M. Ryle Registrar
By M.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4, 1927 to Sep - 24, 1930
that I last saw him alive on Sep - 24, 1930
and that death occurred, on the date stated above, at 11 40 A m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio - Sclerosis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) C. C. Cannon, M. D.
Sep - 26 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 9/26 1930

20. Undertaker Vassar Mortuary Inc
Address Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72148

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 9-9-2
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 10

2. FULL NAME Baby John Bauch

(a) Residence. No. [illegible] St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 27th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Al Bauch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Springfield Minn
12. MAIDEN NAME OF MOTHER Grace Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Davenport Wash

14. Informant Al Bauch
(Address) Lewiston Ida

15. Filed 10-1, 1930 J. M. Lyle Registrar
By. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 27, 1930
that I last saw h[illegible] alive on Sept 27, 1930
and that death occurred, on the date stated above, at 9:30 A m.
The CAUSE OF DEATH* was as follows:

Steel Burn

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E G Broadbent, M. D.
Sept 22, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	9/28 1930

20. Undertaker Vassar Mortuary — Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 7 1930

PLACE OF DEATH

County of Ada

City of Gamania

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2064

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72149

Local Registrar's No. 35

10

2. FULL NAME Lenora Davis

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 13-1924

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
5	11	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child -

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gamania Ida

PARENTS

10. NAME OF FATHER Edgar W. Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Gamania Ida

12. MAIDEN NAME OF MOTHER Sarah Price

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Gamania Ida

14. Informant Edgar Davis
(Address) Gamania Ida

15. Filed 9/30, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1930, to Sept 22, 1930, that I last saw him alive on Sept 22, 1930, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Absorption from Diphtheria, myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Kerns, M. D.

Sept. 24, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gamania Ida	Sept. 25 1930

20. Undertaker	Address
J. Guy Benson	Malad Ida

TION is very important. See instruction on back of certificate.

RECEIVED OCT 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7215

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 34

PLACE OF DEATH

County of Oneida
City of Malad
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

105

2. FULL NAME David Maggs

(a) Residence. No. Malad City, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. 6 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Welsh	Possibly divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 5, 1882.

7. AGE	Years	Months	Days	If LESS than 1 day,
	48	9	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Waunarlwydd
(State or country) South Wales

PARENTS

10. NAME OF FATHER Geo. Maggs.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Mary Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) South Wales

14. Informant James R. Jones
(Address) Malad, City

15. Filed 9/30, 1930 J. McHenry
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 11 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930, to Sept 11, 1930
that I last saw h[illegible] alive on Sept 11, 1930
and that death occurred, on the date stated above, at 10 m.
The CAUSE OF DEATH* was as follows:
Asthma
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Herms M. D.
9/11, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	Sept. 14 1930
20. Undertaker	Address
J. Guy Henman	Malad Ida

TION is very important. See instruction on Back of certificate.

RECEIVED OCT 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72151

PLACE OF DEATH

County of .....

City of .....

Registration District No. 266

Primary Registration District No. 2069

Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

10

2. FULL NAME Ruth Elaine Richards

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Nov. 12 - 1926

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 3 | Months 9 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Malad Ida.

PARENTS

10. NAME OF FATHER: Robert S. Richards

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Malad Ida.

12. MAIDEN NAME OF MOTHER: Irene Goddard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Malad Ida

14. Informant: Robert G. Richards
(Address) Malad Ida

15. Filed 9/30, 1930. J. M. Harris, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1930, to Sept 5, 1930

that I last saw her alive on Sept 5, 1930

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary): Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. M. Harris, M. D.

9/5, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida | Date of Burial: Sept 6 1930

20. Undertaker: J. Guy Benson | Address: Malad Ida

TION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72152

PLACE OF DEATH
County of Payette
City of Payette

CERTIFICATE OF DEATH
Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 30
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Martha E. Lewis 90

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Noah W. Lewis

6. DATE OF BIRTH (month, day and year) Jan 7 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	9	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Penn
(State or country)

PARENTS

10. NAME OF FATHER Ross A. Tait

11. BIRTHPLACE OF FATHER (city or town) Penn
(State or Country)

12. MAIDEN NAME OF MOTHER Isabel S. Sharer

13. BIRTHPLACE OF MOTHER (city or town) Penn
(State or Country)

14. Informant Harry T. Lewis
(Address) Payette Ida

15. Filed Sep 8, 1930 J. O. Woodward
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1928, to Sept 7, 1930
that I last saw her alive on Sept 7, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

arteriosclerosis
cardio-renal-hypertension
disease
indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? none

(Signed) Maurice R. Cox, M. D.
Sept 9, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth Ida.	Sept 9 1930

20. Undertaker	Address
Glenn C Sanders	Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7215

PLACE OF DEATH
County of Fayette
City of Fayette
Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 29
(No. 31)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James C Lakey
(a) Residence No. 0 St.
(Usual place of abode.)
(If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 20 1865

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	1	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stone mason Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ore

PARENTS
10. NAME OF FATHER John Lakey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER ✓ Tooker
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant J. H. Uday (from Records)
(Address) Payette

15. Filed Sept 6, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug 1, 1930, to Sept 5, 1930,
that I last saw him alive on Sept 5, 1930,
and that death occurred, on the date stated above, at 12 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(duration) Indefinite yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) O. H. Avery, M. D.
Sept 6, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal: Pioneer Ida — Date of Burial: Aug 7 1930
20. Undertaker J. H. Uday — Address: Peterson Furn Co Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7215

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 28
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Alice Zora Schubert

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

6a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Levi C. Schubert.

6. DATE OF BIRTH (month, day and year) Sept 18 1863.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	66	11	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Samuel Stahl

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Sarah Pettinger

13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) L. C. Schubert Payette Idaho

15. Filed Sept 1, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1930, to Aug 31, 1930
that I last saw her alive on Aug 27, 1930
and that death occurred, on the date stated above, at 5:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
Chronic interstitial nephritis

(duration) 3 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)
(duration) X yrs. X mos. X ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of
Was there an autopsy? no What test confirmed diagnosis? Clinical & Lab.

(Signed) W. D. Weese M. D.
Sept 1, 1930 (Address) Ontario Ore.

19. Place of Burial, Cremation, or Removal: Payette Ida. — Date of Burial: Sept 1 1930

20. Undertaker: Glenn C Sanders — Address: Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72155

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 27
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles A Garver

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rachel A Garver

6. DATE OF BIRTH (month, day and year) Dec 5 1860

7. AGE: Years 69, Months 8, Days 20. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER John Garver
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Md
12. MAIDEN NAME OF MOTHER Polmer
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Md

14. Informant (Address) Mrs Rachel Garver Payette Ida

15. Filed Aug 26, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Aug 25, 1930
that I last saw him alive on Aug 25, 1930
and that death occurred, on the date stated above, at 10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pernicious anaemia

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Blood smear.
(Signed) Merrill R. Fox, M. D.
Aug 26, 1930 (Address) Payette Ida.

19. Place of Burial, Cremation, or Removal: Payette Ida
Date of Burial: Aug 26 1930

20. Undertaker: Jo H Adair
Address: Peterson Furn Co Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72156

PLACE OF DEATH

County of Gayette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1005
Local Registrar's No. 26
(No. 49)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lars Christian Jensen

(a) Residence. No. 408 - 3 ave. South St.
(Usual place of abode.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Grace E. Jensen

6. DATE OF BIRTH (month, day and year) Nov 23

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Andrew Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Wilhimina Nielsen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant (Address) Grace E Jensen Payette Idaho

15. Filed Aug 22 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1910, to Aug 12, 1930
that I last saw him alive on Aug 12, 1930
and that death occurred, on the date stated above, at 5:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 15 1925
Was there an autopsy? No
What test confirmed diagnosis? Microscopic

(Signed) J R Woodward M. D.
Aug 21, 1930 (Address) Payette, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
New Plymouth	Aug 23 1930
20. Undertaker	Address
Glenn C Sanders	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72157

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 25
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otis L Clark

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Irene Clark

6. DATE OF BIRTH (month, day and year) Jan 29 - 1900

7. AGE Years 30 Months 6 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Piano & Radio
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebr

PARENTS
10. NAME OF FATHER William Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich
12. MAIDEN NAME OF MOTHER Ella Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ills

14. Informant (Address) Ella C Clark Payette

15. Filed Aug 21, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19..., to —, 19...
that I last saw him alive on —, 19...
and that death occurred, on the date stated above, at 11.15 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
accidentally killed by fall of gravel in gravel Apt.
Broken back (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) J C Woodward M. D.
8/21/30, 19..... (Address) Payette Id

19. Place of Burial, Cremation, or Removal Nampa Date of Burial Aug 22 1930

20. Undertaker J. Hedges Address Peterson Furn Co Payette

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72158

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 24
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Mrs Millie Goforth
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widowed
5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Calvin Goforth
6. DATE OF BIRTH (month, day and year)
7. AGE Years 75 Months — Days 4 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS
10. NAME OF FATHER S. Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Hannah Walden
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) Wm Goforth Fruitland Ida
15. Filed Aug 15, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 13 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930 to Aug 13, 1930
that I last saw her alive on Aug 13, 1930
and that death occurred, on the date stated above, at 3 P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Left sided pneumonia lobar.
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Hypertension & Cardio renal disease (duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Federic Bo Knop M. D.
Aug 14, 1930 (Address) Ontario Ore

19. Place of Burial, Cremation, or Removal New Plymouth Ida
Date of Burial Aug 15 1930
20. Undertaker Glenn C Landon
Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72159

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 23
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. **FULL NAME** Mary Hartung

(a) Residence. No. 424 North 4th St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thos. Hartung.

6. DATE OF BIRTH (month, day and year) Oct 20 1857.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	10	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Solomon Faust.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant Chas. Hartung.
(Address) Payette, Ida.

15. Filed Aug 2, 1930 J. C. Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1910, 19..., to Aug 1, 1930
that I last saw her alive on Aug 1, 1930
and that death occurred, on the date stated above, at 11 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hemiparalysis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) F. R. Woodward M. D.
Aug 2, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Ida.	Aug 3 1930
20. Undertaker Glenn C Sanders.	Address Payette. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72160

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 22
(No. 167)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Thomas H. Jefferies

(a) Residence. No. ..... St. .....
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 5, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Kenneth L. Jefferies
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Jo Nell Wilbur
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) Mrs. Claude Jeffries Midvale, Idaho

15. Filed July 26, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930 to July 23, 1930
that I last saw h[illegible] alive on July 23, 1930
and that death occurred, on the date stated above, at 4 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Malnutrition

(duration) ..... yrs. ..... mos. 19 ds.
CONTRIBUTORY (Secondary) Pemphigus
(duration) ..... yrs. ..... mos. 19 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. C. Woodward M. D.
July 24, 1930 (Address) Payette Ida.

19. Place of Burial, Cremation, or Removal: Weston Idaho — Date of Burial: July 26 1930

20. Undertaker: Glenn C Sanders — Address: Payette, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72161

PLACE OF DEATH

County of Payette

City of Payette

Registration District No. 4

Primary Registration District No. 1008

Local Registrar's No. 21

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

135

2. FULL NAME Willard Allen Alden

(a) Residence. No. 1018 North Sixth St. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margret Jane Prettyman Alden

6. DATE OF BIRTH (month, day and year) Dec 8 - 1847

7. AGE: Years 83, Months 9, Days 7. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): New York

PARENTS

10. NAME OF FATHER: Enoch Henry Alden

11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York

12. MAIDEN NAME OF MOTHER: Charlott Seymore

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New York

14. Informant: E H Alden

(Address) Payette Idaho

15. Filed July 16, 1930 J C Woodward Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to July 15, 1930 that I last saw him alive on July 15, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy (benign)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Merrill R. Tot, M. D.

July 17, 1930 (Address) Payette Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Payette Idaho — Date of Burial: July 17 1930

20. Undertaker: Glenn C Landon — Address: Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72162

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 20.
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maude M Stroup

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of S C Stroup

6. DATE OF BIRTH (month, day and year) Feb 2 1891

7. AGE Years 39 Months 4 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) S. D.

PARENTS
10. NAME OF FATHER John F McClure
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Ada A Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) I H Adair Payette

15. Filed July 14, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day), 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930 19....., to July 12/1930 19.....
that I last saw her alive on July 6, 1930 19.....
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
about 1 yr. ..... mos. ..... ds.
(duration)

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Lab Finding "TB"
(Signed) J C Woodward M. D.
July 13, 1930 (Address) Payette Id

19. Place of Burial, Cremation, or Removal Payette
Date of Burial July 13 1930

20. Undertaker I H Adair Peterson Furn Co
Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72168

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 23

Primary Registration District No. 2012

Local Registrar's No. 22

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Emile Allee

(a) Residence. No. Neern Rockland. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	67			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) France

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) France

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France

14. Informant Mrs Joe Thompson
(Address) American Falls, Idaho

15. Filed 9-28-1930 Genevieve Nott Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Sept 27, 1930 that I last saw him alive on Sept 26, 1930 and that death occurred, on the date stated above, at 4:30 a m.

The CAUSE OF DEATH* was as follows: (Pneumonia (lobar)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. F. Adult, M. D.

9/27/30, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rockland, Idaho	9/28/30 19

20. Undertaker C. W. Davis Address Am Falls, Id

TION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 3 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power

City of ..... (No. ....., ... St.)

Registration District No. 23

Primary Registration District No. 2072

File No. 72165

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Arthur Rast

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Sept. (Month) 13 (Day) 1930 (Year)

7. AGE ....Yrs....Mos. 3 ds. IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Erhart Arthur Rast

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Alvina H. Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Erhart A. Rast
(Address) American Falls

15. Filed Oct 1 1930 Geneva Holt Local Registrar

MEDICAL CERTIFICATE OF DEATH

62

16. DATE OF DEATH Sept (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1930, to Sept 16 1930, that I last saw h.....alive on Sept 15 1930 and that death occured on the date stated above, at 4½ P M.

The CAUSE OF DEATH* was as follows:
Never able to restore property

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) Cleft Palate
.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. F. Schultz M. D.
9/17 1930 (Address) Amer. Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rockland	9/19 1930
20. UNDERTAKER None	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72165

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 49

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1130

2. FULL NAME Donald Louis Dupuis

(a) Residence. No. St. Mason
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ——
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg

PARENTS

10. NAME OF FATHER Louis Willford Dupuis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Spokane Wn

12. MAIDEN NAME OF MOTHER Violet Snider

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Culdesac, Idaho

14. Informant Louis Wilford Dupuis
(Address) Kellogg - Ida

15. Filed 9/30, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Sept 28, 1930
that I last saw h[illegible] alive on Sept 30. 9:30 PM, 1930
and that death occurred, on the date stated above, at 11:20 P. m.
The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. R. Musser, M. D.
Sept 30, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Ida	Sept 30 1930
20. Undertaker [illegible] Thornhill	Address Kellogg Ida

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72166

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 48
(No. 206)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Baumann
(a) Residence. No. Pine Creek St. Kellogg Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day,
			Still born 1 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kingston Idaho
(State or country)

PARENTS
10. NAME OF FATHER Fred Baumann
11. BIRTHPLACE OF FATHER (city or town) Kingston Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth DeGraff
13. BIRTHPLACE OF MOTHER (city or town) Penn Idaho
(State or Country)

14. Informant Fred Baumann
(Address) Kellogg Idaho

15. Filed 9/28, 1930 Mrs. Helen McBride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
August 13th, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Premature Cy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. L. Lindsay, M. D.
9/30, 1930, (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Baumann Cemetery Pine Creek	8/14 1930
20. Undertaker	Address
M. C. Thornhill	Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

18422 7

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7216

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 3201
Local Registrar's No. 47
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grette B Patterson 90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of James A Patterson

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs, or ..... min.
61	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Crockett
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant C N Patterson
(Address) Kellogg Ida

15. Filed Sept. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930, to Sept 22, 1930
that I last saw her alive on about July, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Cardiac failure.
(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical.
(Signed) T W Laraway, M. D.
9-24, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood	Sept 25 1930
20. Undertaker M C Thackrey	Address Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72168

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 46

186

2. FULL NAME Philip Clark
(a) Residence. No. Kellogg, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Clark

6. DATE OF BIRTH (month, day and year) July 15 - 1890

7. AGE: Years 40, Months 2, Days 4. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spokane Washington

PARENTS

10. NAME OF FATHER James Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Sarah Nicklan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs C. E. Sizelove
(Address) Kellogg Idaho

15. Filed Sept. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from On, 19—, to Sept 19, 1930
that I last saw him alive on Sept 19, 1930
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Severe crushing injury particularly in the region of the abdomen due to a fall of ground in a lead silver mine (duration) yrs. mos. ds. Patient died about two minutes after reaching hospital which prevented a more exact (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)

18. Where was disease contracted if not at place of death? Diagnosis
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo H Kennett M. D.
Sept 20, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash. Date of Burial: Sept 22, 1930

20. Undertaker: M. P. Thornhill Address: Kellogg, Idaho

RECEIVED OCT 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72170

PLACE OF DEATH
County of Shoshone
City of Kellogg.

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 44

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1013

2. FULL NAME Isaac Wilford Fields

(a) Residence. No. Garfield Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha Isabelle Fields

6. DATE OF BIRTH (month, day and year) Oct 8th 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield Ill.

PARENTS

10. NAME OF FATHER David Fields
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Maria Merritt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs Martha Fields
(Address) Kellogg Id.

15. Filed Sept. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7th, 1930, to Sept 8th, 1930.
that I last saw him alive on Sept 8th, 1930.
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) old age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W C Lindsay, M. D.
9/9, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Garfield Wash	Sept 10 1930
20. Undertaker M. C. Thornhill	Address Kellogg Ida

SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Item 18 is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19

RECEIVED OCT 8 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Teton

City of Driggs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ..... St.)

File No. 72171

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Beryl Floyd Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 9/4 1930 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many 2 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho. Driggs,

10. NAME OF FATHER: Leland Moore

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Harriet Davidson

13. BIRTHPLACE OF MOTHER (State or Country): Nys.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leland Moore

(Address) Driggs, Idaho.

15. Filed 10-4-1930

Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: 9/4 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/4 1930, to 9/4 1930, that I last saw him alive on 9/4 1930, and that death occurred on the date stated above, at 8:00 P M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. R. Reaver M. D.

9/5 1930 (Address) Driggs, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Anthony, Idaho.

DATE OF BURIAL: 9/6 1930

20. UNDERTAKER: W. M. Hansen

ADDRESS: St. Anthony, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72174

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 153

2. FULL NAME Loren Lee Hubbell

(a) Residence. No. 277 Quincy St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 25-1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
00	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Twin Falls
(State or country) Ida

PARENTS

10 NAME OF FATHER Louis J. Hubbell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Iowa

12 MAIDEN NAME OF MOTHER Violet Clark

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Iowa

14 Informant Mrs Violet Hubbell
(Address) 277 - Quincy St.

15 Filed Sept 26th, 1930 Elizabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 15 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1930, to 9/15, 1930, that I last saw him alive on 9/15, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:
Diarrhoea and enteritis 1 3

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. D. Weaver, M. D.

9/16, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	9-17 1930
20. Undertaker	Address
White Mortuary Inc.	Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72175

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2086
Local Registrar's No. 151

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elsie Caire

(a) Residence. No. Oakland Cal St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred, yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

92

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 21 1884

7. AGE 46 Years 1 Months 22 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cal

PARENTS
10. NAME OF FATHER E. Fithian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant J. B. Caire
(Address) Oakland Cal

15. Filed Sept. 15th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Deceased found dead
that I last saw the alive on ....., 19....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Thrombosis of the right Arteries of the heart with Arteriosclerosis 92
..... (duration) ..... yrs. ..... mos. Less than one day.

CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? By Autopsy
(Signed) H. E. Lamb, M. D.
Sept 14th 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Done Cal Date of Burial Sept 1930

20. Undertaker F. C. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72176

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2086
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 152

2. FULL NAME Robert Marvin Smith
(a) Residence. No. Filer Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE of~~ Frank Dolan

6. DATE OF BIRTH (month, day and year) June 22-1930

7. AGE Years — Months 2 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Boise Idaho Ada County

PARENTS

10. NAME OF FATHER Frank Dolan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Buhl Idaho
12. MAIDEN NAME OF MOTHER Marion Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) McKenzie Charleston, No. Dake

14. Informant Marion Smith Dolan
(Address) Filer Idaho

15. Filed Sept 26th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1930, to Sept 12th, 1930
that I last saw him alive on Sept 11th, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
acute Inanition 16'

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Malnutrition
..... (duration) ..... yrs. one mos. ..... ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of .....
Was the [redacted] autopsy? no
What te[redacted]med diagnosis? clinical
(Signed) H. E. Lamb, M. D.
Sept 14, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer
Date of Burial: Sept. 14 19[illegible]

20. Undertaker: F. Drake
Address: Twin Falls

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72177

PLACE OF DEATH
County of Jerome
City of Eden

Registration District No. 37
Primary Registration District No.

Local Registrar's No. 150

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ida Jane Davis

(a) Residence. No. Eden St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Laframes Davis

6. DATE OF BIRTH (month, day and year) Oct 2 - 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Crawford Co. Mo.

PARENTS

10. NAME OF FATHER Isaac King

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Salina Lawlas

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. Henry Schwab
(Address) Eden Idaho

15. Filed Sept 15th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1930, to Sept 12, 1930
that I last saw her alive on Sept 12, 1930
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:

Nephritis 12 d
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? e
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? P C e
(Signed) J. E. Langenwalter, M. D.
Sept 13, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	9-14 1930
20. Undertaker White Mortuary Serv.	Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72178

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. 236 6th East)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 147

2. FULL NAME Kate F. Burton
(a) Residence. No. 236 6th Ave East St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 3 1858

7. AGE Years 72 Months 6 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER James Ferguson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Phyllis Hardy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Chas H. Burton
(Address) 236 6th Ave East

15. Filed Sept-13th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1930, to Sept 11th, 1930
that I last saw her alive on Sept 9th, 1930
and that death occurred, on the date stated above, at 1:30 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Colon 45
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Salt Lake City
Did an operation precede death? Yes Date of Oct. 1929.
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John F. Laughlin M. D.
9-11 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Salt Lake City Ut. Date of Burial 19

20. Undertaker J. J. Grossman Twin Falls Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72179

RECEIVED OCT 14 1930

PLACE OF DEATH
County of Twin Falls
City of 11 11
Registration District No. 37
Primary Registration District No. 1086
Local Registrar's No. 149
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verda Dilbi

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 30

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER James E Wray
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Elizabeth Mayler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant James E Wray
(Address) Twin Falls

15. Filed Sept. 15th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16, 1930, to Sept. 8, 1930
that I last saw her alive on Sept 8, 1930
and that death occurred, on the date stated above, at 7.35 p.m.

The CAUSE OF DEATH* was as follows:
Tonsilitis + quinsy 10 D
Bilatural posterior lobar pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) lobar pneumonia
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. E. Langenwalter, M. D.
Aug 11, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	Sept 9 1930
20. Undertaker	Address
T. J. Grossman	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72180

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2086
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 148

2. FULL NAME Mrs Joe Simon
(a) Residence. No. Filer St.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 23 1893
7. AGE Years 36 Months 8 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Alsac Lorain

PARENTS
10. NAME OF FATHER John Zenner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Alsac Lorain
12. MAIDEN NAME OF MOTHER Katherine Klaus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alsac Lorain

14. Informant Mrs. Henry Powell
(Address) Twin Falls

15. Filed Sept. 15th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Sept 8, 1930
that I last saw her alive on Sept 8, 1930
and that death occurred, on the date stated above, at 7:20 a.m.
The CAUSE OF DEATH* was as follows: 1430
Toxemia from paretic bowel
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hemorrhage 1 Month Anemia
Caesarian Section Sept. 4th
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Sept 4-1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F. A. Dwight, M. D.
Sept 12, 1930 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Cemetery Date of Burial Sept 12 1930
20. Undertaker F. C. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72181

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 146
(No. Co Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Lillian Johnson
(a) Residence. No. Twin Falls Ida RFD 1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Johnson

6. DATE OF BIRTH (month, day and year) Jan. 5 1878

7. AGE Years 52 Months 8 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mass.

PARENTS
10. NAME OF FATHER L. D. Berch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont know
12. MAIDEN NAME OF MOTHER Lydia Winden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Daniel F. Johnson
(Address) Twin Falls R.F.D. #1

15. Filed Sept. 13th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th, 1930, to Sept 6th, 1930
that I last saw her alive on Sept 6th, 1930
and that death occurred, on the date stated above, at 8 PM.
The CAUSE OF DEATH* was as follows:
Endo-myo-Peri Carditis Chronic. with decompensation 88a
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cellulitis Chronic pelvic Epilepsy
(duration) ? yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Xray & Laboratory
(Signed) Duncan L. Alexander M.D.
Sept 8th, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Sept 8 1930

20. Undertaker [illegible] Grossman
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72183

Local Registrar's No. 145

2. FULL NAME Flora Idora Dunham

129

(a) Residence. No. 1126 - 6th Ave E. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: O. H. Dunham

6. DATE OF BIRTH (month, day and year): June 8 - 1865

7. AGE: Years 65 | Months 2 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Crawfordsville Ind.

PARENTS

10. NAME OF FATHER: Albert E. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Maria Rush

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Indiana

14. Informant: Mrs J G Hayden

(Address) 1126 - 6 Ave East

15. Filed Sept 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1930, to Sept 2, 1930

that I last saw her alive on Sept. 1, 1930

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary): Mitral regurgitation

(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. D. Weaver, M. D.

9/2, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. ~~Place of Burial, Cremation, or~~ Removal: Kemmerer Wyo. | Date of Burial: 19

20. Undertaker: White Mortuary Inc | Address: Twin Falls, Ida.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72184

PLACE OF DEATH
County of Twin Falls
City of " "
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 144
(No. Co. Gen. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Edward Klingstrom

(a) Residence. No. 543 Main Ave West St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) WIFE of Jennie Johnson Sweden

6. DATE OF BIRTH (month, day and year) Don't know

7. AGE	Years	Months	Days	If LESS than 1 day,
	58			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER John Klingstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Don't know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Charles Holmes
(Address) Idaho Falls Ida RFD 7

15. Filed Sept 12th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28th, 1928, to Sept 1st, 1930
that I last saw him alive on Sept 1st, 1930
and that death occurred, on the date stated above, at 10:55 A m.
The CAUSE OF DEATH* was as follows:
Nephritis Chronic Interstitial Hypertension (270)
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Apoplexy
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & Clinical
(Signed) Duncan L. Alexander, M. D.
Sept 3, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Sept. 5 1930
20. Undertaker: C. J. Grossman — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72185

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
(No. Twin Falls County Hospital)
Local Registrar's No. 167
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME John Ernest Bergen
(a) Residence. No. Filer St. Ida Coughlin 41
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 20 - 1916

7 AGE Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
15	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10 NAME OF FATHER George L. Bergen
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Born on ocean on way here from
12 MAIDEN NAME OF MOTHER Ethel Simpson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newark N.J.

14 Informant George L. Bergen
(Address) Filer, Idaho

15 Filed Oct. 6th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 29 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-25, 1930, to 9-29, 1930, that I last saw him alive on 9-29, 1930, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH was as follows:
Streptococcus Septicemia
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) acute articular rheumatism
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W. Coughlin M. D.
9-30 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	10-3 1930
20. Undertaker White Mortuary Inc	Address Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72186

PLACE OF DEATH
County Sun Falls
City of Sun Falls

Registration District No. 37
Primary Registration District No. 1085
(No. 752 2 ave E. Mrs Kirk Convention)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. n163

2. FULL NAME Baby Averett Thelma
(a) Residence. No. Eden St. Dr Chancheck
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fe Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years — Months — Days — If LESS than 1 day, 10 hrs. or min.
8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER C B Averett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Hazel Henry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant C B Averett
(Address) Eden

15. Filed Oct. 4, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH 10

16. DATE OF DEATH Sept. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Sept 29, 1930, that I last saw her alive on Sept 29, 1930 and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows: Atelectasis. 163
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) H W Chancheck M. D.
Sept 29, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Sun Falls Date of Burial Sept 30 1930
20. Undertaker T C Drake Address Sun Falls

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7215

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
(No.)
Local Registrar's No. 164

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Charles Lewis Simmons

(a) Residence. No. Filer - Ida St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74A

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva Simmons

6 DATE OF BIRTH (month, day and year) Nov - 5th - 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Franklin County Virginia

PARENTS

10 NAME OF FATHER Fletcher Simmons
11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia
12 MAIDEN NAME OF MOTHER Lucy Hughes
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. C. E. Carder
(Address) Filer, Ida

15 Filed Oct. 4, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 28 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 27, 1930, that I last saw him alive on Sept 27, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. L. Dunglux, M. D.
Sept. 29, 1930 (Address) Filer, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Lawrence, Kansas	
20. Undertaker White Mortuary, Inc	Address Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72188

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
(No. Home 535-5th ave E)
Local Registrar's No. 165

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Baby Bridges

(a) Residence. No. 535 - 5th ave E St.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	X	X	X	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work X
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Twin Falls Ida

PARENTS

10 NAME OF FATHER Boyd J. Bridges
11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington
12 MAIDEN NAME OF MOTHER May Allen
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant B. J. Bridges
(Address) Twin Falls Ida. 535-5th ave E.

15 Filed Oct. 4, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 28 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Sept 28, 1930, that I last saw him alive on Sept 28, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Patent ductus arteriosus

(duration) yrs. mos. 1/6 ds.

CONTRIBUTORY (Secondary) Weak baby.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? C C

(Signed) F. C. Langenwalter M. D.
Sept 29, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Twin Falls Ida	9-29 1930

20. Undertaker White Mortuary
Address Twin Falls, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72189

Registration District No. 37
Primary Registration District No. 2081
Local Registrar's No. 166

PLACE OF DEATH
County Twin Falls
City of Mustang
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard L. Runyan

(a) Residence. No. across from depot St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	3	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER H. A Runyan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Velva Berry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant H A Runyan
(Address) Mustang Idaho

15. Filed Oct 4, 1930 Elizabeth G. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930 to Sept 27, 1930
that I last saw him alive on Aug 25, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Marasmus 160

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Congenital Syphilis (duration) yrs. life mos. ds.

18. Where was disease contracted if not at place of death? 0
Did an operation precede death? 0 Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J M Davis, M. D.
9/27/30 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Artesian	Sept 28 1930
20. Undertaker	Address
F C Drake	Twin Falls

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72191

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 1085
(No. 461 2nd Ave West)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 161

2. FULL NAME Mrs. Eliza Woodhead
(a) Residence. No. 461 2nd Ave West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 8 1853

7. AGE: Years 76, Months 10, Days 14. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England

PARENTS
10. NAME OF FATHER: John Fletcher
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Hoffman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: James Woodhead
(Address) 461 2nd Ave. West.

15. Filed Sept 27, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to Sept. 22, 1930
that I last saw her alive on Sept 22, 1930
and that death occurred, on the date stated above, at 7:00 a.m.
The CAUSE OF DEATH* was as follows: Diabetes 57
(duration) Several yrs. — mos. — ds.
CONTRIBUTORY (Secondary) —
(duration) — yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Lab.
(Signed) C A Engel, M. D.
Sept. 23, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Sept 25 1930

20. Undertaker: J J Grossman
Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72192

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No.) Dr Lamb
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 159

2. FULL NAME J. L. Ainsworth
(a) Residence. No. 437 Walnut St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 20 1878
7. AGE 52 Years Months 4 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah
PARENTS
10. NAME OF FATHER Joseph Ainsworth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Hampson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah
14. Informant Miss Ainsworth
(Address) Twin Falls
15. Filed Sept 27th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 21 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1930, to Sept 20th, 1930
that I last saw him alive on Sept 20th, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Cardio vascular Renal disease.
96
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina Pectoris
(duration) yrs. 3 mos. ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb, M. D.
Sept 22 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls | Date of Burial Sept 23 1930
20. Undertaker F. E. Drake | Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72193

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 158

44a

2. FULL NAME John Stokes Wiseman

(a) Residence. No. Hansen - Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie B. Wiseman

6 DATE OF BIRTH (month, day and year) May 3 - 1879

7 AGE: Years 51, Months 4, Days 16 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mitchel County N. Carolina

PARENTS
10 NAME OF FATHER: Martin Wiseman
11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina
12 MAIDEN NAME OF MOTHER: Tilda Gurley
13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Mrs. Annie B. Wiseman
(Address) Hansen, Ida

15 Filed Sept. 27th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 19 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1930, to Sept 19, 1930, that I last saw him alive on Sept. 19, 1930, and that death occurred, on the date stated above, at 11:40 p m.

The CAUSE OF DEATH* was as follows:
Circulatory Failure due to Endocarditis - (Mitral Insufficiency)
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Infection (Chr.) Base of Lung mediastinal Space + Liver
(duration) 20 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Tennessee + Colorado
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phys. exam + Chem
(Signed) Lab. Dr John R Morgan, M. D.
9/19, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Twin Falls Cemetery — Date of Burial: 9-24 1930

20. Undertaker: White Mortuary Inc — Address: Twin Falls Ida

MARGIN RESERVED FOR LAMINATION

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72194

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 127

PLACE OF DEATH
County Twin Falls
City of Murtaugh
(No. 20)
(If death occurred in a hospital or institution, give name instead of street and number.)

2. FULL NAME Mary E Pratt

(a) Residence. No. Da Capra Villa St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 15

7. AGE: Years 71 | Months 9 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Jas Michell
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Sarah Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Frank Pratt
(Address) Hood River Ore

15. Filed Sept 27th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 18 (Month) (Day) 1930 (Year) 3 days

17. I HEREBY CERTIFY, That I attended deceased from Unattended, 19..., that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Chronic 90
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no —
What test confirmed diagnosis? general

(Signed) H. E. Drake Coroner
Sept 30, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer — Date of Burial: Sept 30 1930

20. Undertaker H. E. Drake Address Twin Falls

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72195

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 156

2. FULL NAME Mary Lucy

(a) Residence. No. Paola Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Mar. 13 1858
7. AGE: Years 72 | Months 6 | Days 5 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10. NAME OF FATHER: Isaiah Green
11. BIRTHPLACE OF FATHER (city or town) (State or Country): N C
12. MAIDEN NAME OF MOTHER: Mary McKinney
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N C

14. Informant: Beloh Cravaness
(Address): Paola

15. Filed Sept 26 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31, 1930, to Sept 18, 1930, that I last saw h[er] alive on Sept 18, 1930, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:
Cardio Vascular - Renal Disease
9 yrs
(duration) 15 yrs. mos. ds.
CONTRIBUTORY (Secondary) Coronary Thrombosis
(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? yes.
What test confirmed diagnosis?
(Signed) A. A. Newberry M. D.
9/19, 1930 (Address) Filer Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paola Cem. Date of Burial: Sept 19 1930
20. Undertaker: F. C. Drake Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72196

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2185
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)
Local Registrar's No. 15-4

2. FULL NAME Alma Dell Reynolds 119

(a) Residence. No. Hansen, Ida St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 30 - 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1	2	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Twin Falls Idaho

PARENTS
10 NAME OF FATHER J A. Reynolds
11 BIRTHPLACE OF FATHER (city or town) (State or country) Mt Pleasant Utah
12 MAIDEN NAME OF MOTHER Mary Reynolds
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manassa Colo.

14 Informant J A. Reynolds
(Address) Hansen Ida

15 Filed September 27 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 17 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept - 16, 1930, to Sept 17, 1930, that I last saw her alive on Sept - 16, 1930, and that death occurred, on the date stated above, at 1:30A m.

The CAUSE OF DEATH* was as follows:
Ileo Colitis
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hansen Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J N Davis, M. D.
Sept 17, 1930 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	9-18 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72197

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 156
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Glendale Mort

(a) Residence. No. 170 Jackson St. Or Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3 / 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	1	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER R L Mort
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Mary E Worcester
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill

14. Informant Mary Mort
(Address) Twin Falls

15. Filed Sept 26th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Sept. 13, 1930, ~~to~~ that I last saw ~~him~~ alive on Sept. 13, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Diarrhoea and enteritis
113
(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) C. D. Weaver, M. D.
9/20, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Sept 19 1930

20. Undertaker J C Drake — Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED OCT 4 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 72198

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Havilla Drickell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widdow (Write the word.)

6. DATE OF BIRTH. Sept (Month) 21 (Day) 1853 (Year)

7. AGE 77 Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Simon Warner

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Nancy A Miller

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) x J J Wright

(Address)

15. File 10-2-30

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 24 (Day) 1930 (Year)

74a

17. I HEREBY CERTIFY, That I attended deceased from 9/20/30. 191..., to 9/24/30. 191..., that I last saw her alive on 9/20/30 191..., and that death occured on the date stated above, at 9:00A M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio-sclerosis Hypertension

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R T Whiteman M. D.

9/24 1930 (Address) Cambridge, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge

DATE OF BURIAL: 9/25 1930

20. UNDERTAKER: J A Hudelson

ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1930

48

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72199

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

101a

2. FULL NAME Julia N Crawford

(a) Residence No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wh
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Anderson B. Crawford

6. DATE OF BIRTH (month, day and year) Jan 13-1857

7. AGE Years 73 Months 7 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER J. M. Newkirk
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Elizabeth Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo - Carolina

14. Informant Anderson B. Crawford
(Address) Weiser Idaho

15. Filed Aug 29, 1930 W. R. Hamilton Registrar
By S. S.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Aug 28, 1930
that I last saw her alive on Aug 28, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia & Sinility
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at place of D.
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) F A Schmitt, M. D.
8-29, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery
Date of Burial Aug 30- 1930

20. Undertaker
Address

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72260

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 46
Primary Registration District No. 1076

Local Registrar's No. 9

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank R. Hansen

(a) Residence. No. 476 W Court St. (Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): May 29 - 1898

7. AGE: Years 32 | Months 2 | Days 21 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk Soda Fountain
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10. NAME OF FATHER: Niels Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Eva L Hochstrasser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Fred Hansen
(Address) Weiser Idaho

15. Filed Aug 22, 1930 W. R. Hamilton Registrar
By J. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Accidental death by shot gun wound while asst Lunging, death instantaneous (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no organic trouble (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R. C. Northam M. D.
Aug 21, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	8-23-1930
20. Undertaker: R. C. Northam	Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72201

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. 161A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 8

2. FULL NAME Bobby Harvey

(a) Residence. No. Council St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Aug 14 1930
7. AGE: Years — Months — Days — If LESS than 1 day, 7 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Weiser Idaho

PARENTS
10. NAME OF FATHER: Earl Harvey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Lillian Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Earl Harvey
(Address) Council Idaho

15. Filed Aug 15, 1930 W. R. Hamilton Registrar
By L. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Aug 15, 1930, that I last saw him alive on Aug 15, 1930, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:
Premature Infant
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Frederick Tanner, M. D.
Aug 16, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Council - Idaho	Aug 16 1930

20. Undertaker	Address
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED SEP 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72202

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 7

161B

2. FULL NAME Baby Randall
(a) Residence. No. Monroe Creek St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE wht
5. Single, Married, Widowed, or Divorced (write the word) ~~[illegible]~~
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 11 — 1930
7. AGE Years — Months — Days — If LESS than 1 day, 7 hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Edgar Randall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Bernice Wardrop
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Edgar Randall
(Address) Weiser Idaho
15. Filed Aug 12, 1930 W. R. Hamilton Registrar By L. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 11, 1930, to Aug 11, 1930
that I last saw her alive on Aug 11, 1930
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Morbus Cerebrus
9 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? at birth
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? general symptoms
(Signed) G M Waterhouse M. D.
Aug 12, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hillcrest Cemetery — Date of Burial: 8-12-1930
20. Undertaker: L. C. Northam — Address: Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1930

7

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72203

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5

90

2. FULL NAME Archie C. Lassiter
(a) Residence. No. 614 East Main St. Weiser, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Etta J. Lassiter

6. DATE OF BIRTH (month, day and year) born year 1850 - Month Nov, Day 19th

7. AGE Years 79 Months 8 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nashville, Tenn.

PARENTS

10. NAME OF FATHER Harmon Lassiter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nashville, Tenn.
12. MAIDEN NAME OF MOTHER Bettie Wadkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wilson County, Tenn.

14. Informant Mrs. Etta J. Lassiter.
(Address) 614 East Main, Weiser, Ida.

15. Filed July 22, 1930 W. R. Hamilton Registrar By L. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4, 1929, to July 21, 1930
that I last saw him alive on July 21, 1930
and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:
Interna Sclerosis
Myocarditis & Endocarditis
Aortic Regurgitation
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Ernesto Finney M. D.
7 22, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hellcrest Cemetery
Date of Burial: 7-22 1930

20. Undertaker: L. C. Northam
Address: Weiser, Ida

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72204

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

44

2. FULL NAME Lillie May Frank

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John P Frank

6. DATE OF BIRTH (month, day and year) Dec 10 - 1876

7. AGE Years 53 Months 7 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ~~Valparaiso~~ Valparaiso Nebo

PARENTS
10. NAME OF FATHER James A. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Louisa Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky

14. Informant John P. Frank
(Address) Weiser Idaho

15. Filed July 19, 1930 W. R. Hamilton By S. S. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14th, 1930, to July 18th 1930
that I last saw her alive on July 18th 1930
and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of (?)
Was there an autopsy? No.
What test confirmed diagnosis? Operation
(Signed) L. W. R. Hamilton M. D.
July 19, 1930 (Address) Weiser Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 7-20-1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72205

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 3
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gennetta Hartley

(a) Residence. No. 154 W Court St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

164

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Wm H. Hartley
6. DATE OF BIRTH (month, day and year): Sept 15- 1856
7. AGE — Years: 73 | Months: 10 | Days: 0 | If LESS than 1 day, hrs. or min.:
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): California

PARENTS
10. NAME OF FATHER: Geo W. Patterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know
12. MAIDEN NAME OF MOTHER: Elizabeth A Boreaw
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: B Dick Hartley
(Address) Weiser Idaho

15. Filed July 16, 1930 W B Hamilton Registrar
By L. L.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to July 15, 1930
that I last saw her alive on June, 1930
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Paralysis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Weiser Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? General appearance
(Signed) G.M. Haberhorn, M. D.
July 16, 1930 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	7-17-1930
20. Undertaker: L. C. Northam	Address: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED SEP 18 1934

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72266

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 2
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Thomas Gerdeau

(a) Residence. No. 729 E Liberty St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wh	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Anna Gerdeau

6. DATE OF BIRTH (month, day and year) Apr 3 - 1863

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dont Know

14. Informant Arthur Gerdeau
(Address) Weiser Idaho

15. Filed July 9, 1930 W. B. Hamilton By ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1929, to July 7th 1930, that I last saw h.. alive on July 7th 1930 and that death occurred, on the date stated above, at 7 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
gastric Sarcomma.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. L. Lamont, M. D.
July 7th 1930 (Address) Weiser Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	7-10-1930
20. Undertaker L. L. Northam	Address Weiser Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED SEP 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72207

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 8 6
Primary Registration District No. ~~1950~~ 2112

Local Registrar's No. 1

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME John T. Ware

(a) Residence. No. Indian Valley St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Harriet L. Ware

6. DATE OF BIRTH (month, day and year) June 18 - 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
75	8	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant P. H. Ware
(Address) Indian Valley Ida

15. Filed July 1, 1930 W. R. Hamilton Registrar
By J. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Feb 17, 1930
that I last saw him alive on Feb 17, 1930
and that death occurred, on the date stated above, at 3 a. m.
The CAUSE OF DEATH* was as follows:

Senility + Cardiac Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. R. Marshall, M. D.
Feb 18, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

722108

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72208

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 92

PLACE OF DEATH

County of Ada
City of Boise
(No. U. S. V. B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME BENNETT, William

(a) Residence. No. ..... St. Kellogg, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of xx

6. DATE OF BIRTH (month, day and year) 7-10-1898

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	3	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L.H. Beaman
(Address) U.S.V.B., Boise, Idaho

15. Filed 10-17, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 14, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1930 to Oct. 14, 1930
that I last saw him alive on Oct. 14, 1930, 19
and that death occurred, on the date stated above, at 12.05 pm m.

The CAUSE OF DEATH* was as follows:
V.H.D. Mitral insufficiency decompensated;
Cardiac hypertrophy & dilatation severe.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) xx

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) F.C. SMITH, Reg. Med. Officer M. D.
Oct. 15, 1930 19 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct. 16, 1930
20. Undertaker	**Address**
Schreiber & McCann	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

72209

DO NOT WRITE IN THIS SPACE
State File No. 72209

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 91

112

PLACE OF DEATH

County of Ada
City of Boise
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME DAVENPORT, Nelson

(a) Residence. No. Rt. 2 St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Pearl Davenport

6. DATE OF BIRTH (month, day and year) Oct. 15, 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	11	29	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L. H. Beaman
(Address) U. S. Veterans' Bureau, Boise, Idaho

15. Filed 10-17, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1930, to Oct. 14, 1930
that I last saw him alive on Oct. 13, 1930
and that death occurred, on the date stated above, at 4.00 a. m.
The CAUSE OF DEATH* was as follows:
Hemorrhage stomach

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Syphilis tertiary
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy

(Signed) F.C.SMITH, Reg. Med. Officer, M. D.
Oct. 14, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct. 16, 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REC'D OCT 18 1930

72210

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72210

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 50

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No. 170)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ceaser Maggie

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Plummer
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10. NAME OF FATHER Achille Maggie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Filomena Olgiatti
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Mrs. Susan Orlandini
(Address) Kellogg, Idaho

15. Filed Oct. 16, 1930 Mrs. Helen M. Bride
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH was as follows:

Gunshot wound of mouth Suicide

(duration) ... hrs. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 2 wks yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of ...
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) M. Merry Corson M.D.
Sept 29, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood	Sept 1930
20. Undertaker	Address
M. C. Hawley	Kellogg Ida

RECEIVED OCT 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7221

Local Registrar's No. 174

PLACE OF DEATH

County of Twin Falls

City of Twin Falls.

Registration District No. 37

Primary Registration District No. 2085

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Robert Palmer

(a) Residence. No. ..... St. n/a

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. / mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Iva Simmons Palmer

6 DATE OF BIRTH (month, day and year) Aug 30-1891

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stockman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Milford Iowa

PARENTS

10 NAME OF FATHER James A. Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wisconsin

12 MAIDEN NAME OF MOTHER Ella Rankin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant (Mrs.) Iva S. Palmer

(Address) 213 The Reed Twin Falls, Ida

15 Filed Oct. 16 1930 Elizabeth J. Sonntag Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 8 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from October 1, 1930, to Oct. 8, 1930, that I last saw him alive on Oct. 8, 1930, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Influenza Acute Nervous type.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Respiratory paralysis Acute Toxic.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Autopsy-Microscopic examination

(Signed) Dr. Carl L. Reed M.D.

Oct. 11, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	10-12 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 22 1930

72212

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

72212

1 PLACE OF DEATH
County ~~Kend O'Reille~~ Benewah State ~~Wn.~~ Idaho Registered No.
Township ~~Calispell~~ Plummer or Village Indian Reser. or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Chas. Sherie 92

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katharine

6 DATE OF BIRTH (month, day, and year) 8/10/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	71			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Calispell Res.
(c) Name of employer

9 BIRTHPLACE (city or town) ____
(State or country)

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant ____
(Address)

15 Filed ____, 19 ____
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/16 1930

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to Sept. 16, 1930,
that I last saw him alive on Sept. 26, 1930,
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

Thrombosis Coronary artery

Unknown
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) G. M. Gould, M. D.
, 19 (Address) Cusick, Wn.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

RECEIVED OCT 22 1930

5-1142

UNITED STATES

DEPARTMENT OF THE INTERIOR

INDIAN FIELD SERVICE

COEUR D'ALENE INDIAN AGENCY,

WORLEY, IDAHO, R. F. D.

Oct. 20, 1930.

State Health Office,
Boise, Idaho.

Dear Sirs:

There is respectfully forwarded herewith the following death certificate for the month of September:

Chas. Sherie, died Sept. 16, 1930, full blood Kalispell Indian.

Very truly yours,

BYRON A. SHARP

Superintendent & S. D. A. (Symbol 63528)

By _____

Assistant Disbursing Agent

Byron A. Sharp,
Superintendent.

V.
1 Incl.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72213

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006 Local Registrar's No. 15
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John W. Burns
(a) Residence. No. ..... St. Green River, Wyo.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. 6 mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): divorced

5a. ~~If married, widowed~~, or divorced HUSBAND of ~~(or) WIFE of~~ Agnes King

6. DATE OF BIRTH (month, day and year) April 1st 1864

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	6	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Machinist's helper
(b) General nature of industry, business, or establishment in which employed (or employer): Union Pacific
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10. NAME OF FATHER: Burns
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Anne
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ireland

14. Informant (Address): Mrs. Agnes Hartley, Rockland, Idaho

15. Filed 10-6, 1930 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 6th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29, 1930, to 10-6, 1930
that I last saw him alive on 10-5, 1930
and that death occurred, on the date stated above, at 12:40 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Green River, Wyo.
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed ~~diagnosis~~? Kortan
(Signed) ..... M. D.
10-6, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: American Falls, Ida. Date of Burial: 19

20. Undertaker: Wm D. Falley Address: Nampa, Ida.

72214

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72214

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 93

PLACE OF DEATH

County of Ada
City of Boise
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number)

131

2. FULL NAME LOYD, William P.

(a) Residence. No. 425 S. 5th St. St. Pocatello, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 17, 1878

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	9	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tenn.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L.H. Beaman
(Address) U.S.V.B., Boise, Idaho

15. Filed 10-21, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug. 11, 1930; to Oct. 20, 1930
that I last saw him alive on Oct. 20, 1930
and that death occurred, on the date stated above, at 6.26 p. m.
The CAUSE OF DEATH* was as follows:
Uraemia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pyelonephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy

(Signed) F.O. SMITH, Reg. Med. Officer M. D.
Oct. 21, 1930 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Ida	Oct. 23, 1930
20. Undertaker	Address
McHan Undertaking Home	Pocatello, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 24 1930

72215

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72215

Local Registrar's No. 16

PLACE OF DEATH

County of Bonner

City of Newport.

Registration District No. 85

Primary Registration District No. 2185

(No. 170)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME EARL FREDERICK PETER HEDEN

(a) Residence. No. Earl Frederick Peter Heden St. Spokane, Wash.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of Merva Heden.
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 26, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cattle Buyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Spokane
(State or country) Wash.

PARENTS

10 NAME OF FATHER Frank M. Heden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Sweden

12 MAIDEN NAME OF MOTHER [illegible]

12a BIRTHPLACE OF MOTHER (city or town)
(State or country) Sweden

Informant [illegible]

(Address) 710 S. Sheridan Spokane, Wash.

15 Filed Oct. 7, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. (Month) 1, (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Suicide - by firearms.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. H. Moon Coroner, M. D.

Oct. 2, 1930 (Address) Sandpoint, Ida.

*Specify the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Spokane, Wash. Date of Burial: Oct. 4 1930

20. Undertaker: Turnbull-Merager Co. Address: Spokane, Wash.

N. B.—Every fact stated must be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED OCT 23 1930

72216

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72216

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 188 E)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles E. Robenson.

(a) Residence. No. St. Portland, Oregon.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice L. Robenson.

6. DATE OF BIRTH (month, day and year) December 15th, 1883.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46.	10.	4.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Secretary Oregon Packing Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10. NAME OF FATHER Charles E. Robenson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia.

12. MAIDEN NAME OF MOTHER Nannie Davis.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas.

14. Informant C. O. Cockrill.
(Address) Yakima, Washington.

15. Filed 10-29-30, 19 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 19th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4:35 A. M.

The CAUSE OF DEATH* was as follows:

Accidental drowning caused by auto being driven from highway, on a turn, and plunging in river.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. M. Brower Coroner M. D.
10/29, 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Portland, Oregon.	
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED OCT 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

72217

DO NOT WRITE IN THIS SPACE
State File No. 72217

PLACE OF DEATH
County of Bannock
City of Inkom

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5915
(No. Ranch, Inkom, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Carl Thestisen

(a) Residence. No. Ranch, Inkom, Idaho. St. Denmark.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 0 yrs. 10 mos. ds. How long in U. S. if of foreign birth? yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Maria Frederikke Kutzback

6. DATE OF BIRTH (month, day and year) January 8, 1860.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	8	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Moulder
(b) General nature of industry, business, or establishment in which employed (or employer) Foundry
(c) Name of employer Retired

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Hans Tester Thestisen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Nette Kristine Petersen

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark.

14. Informant James Larsen
(Address) Inkom, Idaho.

15. Filed 10/8/30. 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October, 6, 1930. 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1930, to Sept. 16, 1930
that I last saw him alive on Sept. 16, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

I saw patient one afternoon in my office was suffering at that time from a cardio-nephritic condition (duration) Many yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) A. H. Urghart, M. D.
10/8/30. 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. — Date of Burial: 10/8/30. 19....

20. Undertaker: Arthur W. Hall — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

72218

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72218

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 282
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. **FULL NAME** Rev. James Francis Kelly
(a) Residence. No. St. Alphonsus Hospital St. Boise Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1856

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Catholic Priest
(b) General nature of industry, business, or establishment in which employed (or employer) Diocese of Boise
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Rev. Jos. P. O'Toole

15. Filed 10-31, 1930 W. H. Rhoda Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930 to Oct 29, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 8:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
Diabetes mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholycystitis + senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) G. H. Wahl, M. D.
Oct 31, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: St. John's
Date of Burial: 11-3 1930

20. Undertaker: Schreiber & McCann
Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 3 1930

72219

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72219

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. .....
Primary Registration District No. 6
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

178

2. FULL NAME Dwight William Thorning

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12 - 1913

7. AGE 17 Years | Months 3 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sutherland Nebraska

PARENTS

10. NAME OF FATHER Wm. B. Thorning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Hilda Jorgensen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Paxton Nebraska

14. Informant (Address) Ray Lansing Emmett Ida

15. Filed 10/8, 1930 J. K. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental death from gasoline explosion in ranch pump house of C. D. Bucknum Emmett
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. C. Adkins "Coroner" M.D.
10/8, 1930 (Address) Emmett Idaho

19. Place of Burial, Cremation, or Removal Emmett Idaho | Date of Burial 10/8 1930

20. Undertaker C. D. Bucknum | Address Emmett Idaho

72220

REC'D NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72220

Registration District No. 37
Primary Registration District No. 1085
(No.)
Local Registrar's No. 185

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME James P. McClure

(a) Residence. No. 735 - Shoshone St. N.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

131

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Cora M. McClure

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2	3 -	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wholesale Seed Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mercer County Pa.

PARENTS

10 NAME OF FATHER Robert McClure
11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.
12 MAIDEN NAME OF MOTHER Ella Caldwell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant L. L. Breckenridge,
(Address) 137 - 7th Ave N.

15 Filed Oct. 29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 25 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 19th, 1930, to Oct 25th, 1930, that I last saw him alive on Oct 24th, 1930, and that death occurred, on the date stated above, at 7-35 m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. C. Lamb, M. D.
Oct 26th, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	10-26 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 23 1930

72221

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72221

PLACE OF DEATH
County of Nez Perce.
City of Lewiston.

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

188 e

2. FULL NAME Charles J. Clear.

(a) Residence. No. St. Portland, Oregon.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Annette Clear.

6. DATE OF BIRTH (month, day and year): June 18th, 1890.

7. AGE: 40. Years | Months: 4. | Days: 1. | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: President Oregon Packing Co.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): San Diego, California.

PARENTS

10. NAME OF FATHER: Charles Clear,
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mass.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown.

14. Informant: C. O. Cockrill
(Address): Yakima, Washington.

15. Filed 10-19, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 19th, 1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 4:35 A. M.
The CAUSE OF DEATH* was as follows:

Accidental drowning caused by auto being driven from highway, on a turn, and plunging in river. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E M Brower Coroner
10/19, 1930 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland, Oregon. | Date of Burial: 10/21/30 19

20. Undertaker: Brower-Wann Company. | Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No.

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles J. Clear.

(a) Residence. No. St. Portland, Oregon.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18th, 1890.

7. AGE: 40. Years; Months: 4.; Days: 1.; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work President Oregon Packing Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) San Diego, California.

PARENTS

10. NAME OF FATHER Charles Clear.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant O. C. Cockrill
(Address) Yakima, Washington.

15. Filed Oct. 20, 1938 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 19th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 4:35 A.M. m.

The CAUSE OF DEATH* was as follows:

Accidental drowning caused by auto leaving highway on a turn and plunging in Clearwater river. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ed. Brower Grower M. D.

10/19/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Portland, Oregon. Date of Burial 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

RECEIVED NOV 7 1930

72222

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72222

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 77
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1898

2. FULL NAME Carl Aase

(a) Residence. No. Kootenai St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Aase

6. DATE OF BIRTH (month, day and year) Mar 29 1892

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	6	14	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sawyer (woods)

(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Tennyson Aase

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unobtainable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Mrs Martha Aase
(Address) Kootenai

15. Filed Oct. 16, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 8 P. m.

The ~~CAUSE~~ OF DEATH* was as follows:
Traumatism, accidental. Crushed by a falling tree while working in standing timber (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ✓
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No. Date of ...
Was there an autopsy? No
What test confirmed diagnosis? ✓

(Signed) O F Payne M. D.
Oct 17, 1930. (Address) Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	10/19 1930
20. Undertaker	**Address**
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 17 1930
RECEIVED NOV 24 1930

72223

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72223

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

177

2. FULL NAME Gus Daubigny

(a) Residence. No. ..... St. St. Louis, Mo.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 43 Months 7 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St. Louis
(State or country) Mo.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Army Enlistment Papers
(Address)

15. Filed 11/8, 1930 J Byoung Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 6, 1930
that I last saw him alive on Nov 6, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Acute Wood Alcoholic Poisoning
..... (duration) ..... yrs. ..... mos. 1/2 hrs ~~ds.~~
CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Parley Nelson, M. D.
Nov 7th, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation~~, or Removal St. Louis, Mo
Date of Burial 19

20. Undertaker Russel R. Flamm
Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 24 [illegible]

Will you please state whether this was homicide, suicide, or accident? We must have this information before we can send the certificate to Washington.

Thank you,

BUREAU OF VITAL STATISTICS

Please return immediately Justice

Idon't know.

Parker Nelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72224

PLACE OF DEATH
County of Ada
City of

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 95
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Peter Strom
(a) Residence. No. Ranch- 17 miles S.W. of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6. DATE OF BIRTH (month, day and year) Not known

7. AGE Years About 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) Wm. McBratney Boise, Idaho.

15. Filed 10-31, 1930 W. H. R[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct, 20th or 21st, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~, to ~~, 19~~ ~~that I last saw h[illegible] alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at Not Known. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead. Probably acute Heart attack or apoplexy. Had been dead probably 18 or 20 hours when found. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Natural Cause.
No Inquest held. (duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No. —
What test confirmed diagnosis? —
(Signed) W McBratney, Coroner ~~M. D.~~
10/24/1930, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal Morris Hill cemetery | Date of Burial 10/24/30 19

20. Undertaker Wm. McBratney | Address Boise, Ida.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72225

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 941
(No. Ada County Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** James Walter Hussey

(a) Residence. No. ~~.....~~ Star, Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Nora Hussey

6. DATE OF BIRTH (month, day and year) Sept, 19—

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs, or ....min.
	80			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Dayton, Ohio

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) "

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or County) "

14. Informant (Address) Marguerite Andregg Boise, Idaho

15. Filed 10-23, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct — 21 — 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 1, 1930, to Oct 21, 1930
that I last saw him alive on Oct 14, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
& Myocarditis

(duration) 5 yrs. ..... mos. 14 ds.
CONTRIBUTORY (Secondary) Cardiac Decompensation
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? Ada County
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. M. Brayton M. D.
10-21-1930, 19..... (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery	10-23-1930
20. Undertaker	Address
W. McBratney	Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72226

PLACE OF DEATH

County of Ada.
City of Boise Idaho.

Registration District No. 8 V
Primary Registration District No. 2004 Local Registrar's No. 90
(No. 2 miles west of Boise.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sophia Fowler.

(a) Residence. No. 2 miles west of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

THC

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of E. F. Fowler.

6. DATE OF BIRTH (month, day and year) Sept.-25-1853.

7. AGE Years	Months	Days	If LESS than 1 day,
77	0	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germtown Penn.

PARENTS

10. NAME OF FATHER Dr. Glasser.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown

12. MAIDEN NAME OF MOTHER Roseanna Best.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant E. F. Fowler.
(Address) Boise Idaho.

15. Filed 11-[illegible], 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct.-7-1930. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Oct 5, 1930 that I last saw her alive on Oct 5, 1930 and that death occurred, on the date stated above, at 8-30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

about (duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Age also partial paralysis
of left side (duration) Do not know duration yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical tests.

(Signed) Chas. A. Lowe, M. D.
Oct 9, 1930 (Address) 215 1st Nat Bank Boise Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct. 10- 1930
20. Undertaker	Address
Summers & Krebs.	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72226

PLACE OF DEATH
County of Ada.
City of Boise Idaho.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 85
(No. 1/2 mi. W. of Boise)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank S. Dietrich.

(a) Residence. No. 201 W. Jefferson. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha Behle Dietrich.

6. DATE OF BIRTH (month, day and year) Jan. 23, 1863

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Judge of U.S.Court of appl
(b) General nature of industry, business, or establishment in which employed (or employer) Lawyer.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ottowa Kansas.

PARENTS

10. NAME OF FATHER Jacob Dietrich

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Catherine Walruth.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant Isabel Dietrich Grainger.
(Address) Boise Idaho.

15. Filed 10-4, 30 W. N. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct.-2-1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 2, 1930
that I last saw him alive on Sept 30, 1930
~~and~~ on the street
and that death occurred, on the date stated above, at 8:50 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Chronic Myocarditis (From exam. made several years ago for Life Ins.)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis Instant
Probably (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None present
Deadwithin hour. (Signed) J. N. Breshears, M. D.
Oct 3, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct.4 19 30
20. Undertaker	Address
Summers & Krebs.	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72228

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 88
(No. Lambert Addition, 3 Miles west of Boise.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugenie Shipman Kirk.
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Femal
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Kenneth Kirk.

6. DATE OF BIRTH (month, day and year) May-23-1909

7. AGE Years 21 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS
10. NAME OF FATHER John Shipman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario Canada
12. MAIDEN NAME OF MOTHER Jennie Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ontario Canada

14. Informant (Address) Kenneth Kirk. Boise Idaho.

15. Filed 10-4, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct.-1-1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Oct 1, 1930
that I last saw her alive on Sept 27, 1930
and that death occurred, on the date stated above, at 2:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Los Angeles.
Did an operation ~~precede~~ death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab.
(Signed) A. B. Borck M. D.
Oct 2, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Oct-3-1930

20. Undertaker Summers & Krebs.
Address Boise Idaho

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72229

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 281
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Jones Cleveland
(a) Residence. No. 140 E Bannock St St. 90
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 2, 1865

7. AGE 65 Years Months 3 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work — at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Newport Vermont

PARENTS
10. NAME OF FATHER William Curtis Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Aberthanette Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant (Address) Walter J. Cleveland 140 E. Bannock St Boise Ida

15. Filed 10-31, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1930, to Oct 30, 1930
that I last saw her alive on Oct 30, 1930
and that death occurred, on the date stated above, at 4 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rheumatic Valvular Chronic heart Disease.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Articular Rheumatism (duration) 1 yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) Hersly T. Nokes M. D.
Oct 31, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial Nov 2 1930

20. Undertaker Summers & Krefs
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

JM Brock

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72230

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 2611
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Bright Squier

(a) Residence. No. 1321 Manitou Ave. St.
(Usual place of abode.)
Length of residence in city or town where death occured 13 yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	W	Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or)~~ ~~WIFE of~~ Hannah N. Squier

6. DATE OF BIRTH (month, day and year) Oct. 14, 1859

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	0	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hamilton, Ohio

PARENTS

10. NAME OF FATHER Levi P. Squier
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Elizibeth Bright
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant Mrs. Hannah N. Squier
(Address) Boise, Idaho.

15. Filed 10-29 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 26th. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15th 1930, to Oct. 25th 1930, that I last saw him alive on Oct. 25th 1930 and that death occurred, on the date stated above, at 4 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
and Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyorrhea alveolaris

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Brock M. D.
10/27/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill cemetery — Date of Burial: 10/27/30 19

20. Undertaker: Wm. McBratney — Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72231

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 279
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wayne Perkins
(a) ~~Residence.~~ No. Cascade, Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5 1900

7. AGE 29 Years Months 11 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED Construction Foreman
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Utah construction
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Diamondville Wyo

PARENTS
10. NAME OF FATHER Jasper W. Perkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Randolph Utah
12. MAIDEN NAME OF MOTHER Ruth Ferrin
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Eden Utah J.W. Perkins

14. Informant (Address) Chesterfield Idaho

15. Filed 10-29 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Oct 27, 1930
that I last saw him alive on Oct 26, 1930
and that death occurred, on the date stated above, at 1 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Streptococcic meningitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at place of death, Boise
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Spinal fluid examination
(Signed) W. L. Frazier, M. D.
Oct 29, 1930 (Address) 513 Eastman Bldg.

19. Place of Burial, Cremation, or Removal Chesterfield, Utah
Date of Burial 10/30 1930

20. Undertaker Schreiber & McCann
Address Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72233

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 277
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Marie Stuppy

(a) Residence. No. ..... St. 1010
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 6th 1930

7. AGE Years — Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meridian Idaho

PARENTS
10. NAME OF FATHER John Stuppy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) St. Genevieve Mo.
12. MAIDEN NAME OF MOTHER Daisy Hunt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stockton Mo.

14. Informant John Stuppy
(Address) Meridian Ida. Rt. 3

15. Filed 10-27, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 24th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to Oct. 24, 1930
that I last saw her alive on Oct. 24, 1930
and that death occurred, on the date stated above, at 10:10 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) 0 yrs. 0 mos. 4 ds.
CONTRIBUTORY (Secondary) Inanition
(duration) ✓ yrs. ✓ mos. 15 ds.

18. Where was disease contracted if not at place of death? At ranch home
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical findings
(Signed) Harmon Freeman M. D.
10-25, 1930 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Meridian, Idaho — Date of Burial 10-26 1930

20. Undertaker B. W. Robison — Address Meridian Idaho

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72234

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 276
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

64

2. **FULL NAME** Esther Motie Breshears

(a) Residence. No. 712 N. 8 St. 7.
(Usual place of abode.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard R. Breshears

6. DATE OF BIRTH (month, day and year) Aug 11, 1900

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
30	2	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Odebolt Iowa

PARENTS

10. NAME OF FATHER Francis P. Motie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davenport Iowa
12. MAIDEN NAME OF MOTHER Anna B. Matter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lyons Iowa

14. Informant (Address) Mrs. Stephen Regans Ontario Oregon

15. Filed 10-22, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 20 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-9-30 19..., to 10-20-, 1930
that I last saw h.. alive on 10-20-30 19...
and that death occurred, on the date stated above, at 11:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bantis's Disease

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Gastric Hemorrhage
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? yes Date of 10/20/30
Was there an autopsy? yes.
What test confirmed diagnosis? Autopsy
(Signed) Ernest E. Lamb M. D.
10/22/30 19... (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetry — Date of Burial: 10-23 1930
20. Undertaker: Scheuber-McCann — Address: Boise Idaho

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72235

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 275
(No.) 44a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Hattie Cate Brown
(a) Residence. No. 2015, N. 16 street St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E. B. Brown

6. DATE OF BIRTH (month, day and year) Sept. 19, 1864.

7. AGE Years 66 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS
10. NAME OF FATHER Robert E. Cate
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Armind & Stephenson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tenn.

14. Informant (Address) Leona Brown 2015 N. 16 st Boise Ida

15. Filed [illegible], 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 20, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1930, to , 19
that I last saw her alive on Sept. 24, 1930 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
(1) Chr. Endocarditis (Aortic Stenosis, (2) Chr. Aortitis with Debilitation. (3) Hypertension. (4) Coronary Sclerosis (?) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no. Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Ernest E. Lambright, M. D.
10/22/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial Oct 23 1930

20. Undertaker Summers & Kerb Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72236

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus)
Local Registrar's No. 274
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lucile Ellen Dunn

(a) Residence. No. 1404 N. 14 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James R Dunn

6. DATE OF BIRTH (month, day and year) Jan 10 1913

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Emmett Ida

PARENTS

10. NAME OF FATHER Lee Alfred Grafe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Clara Phillips
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Weiser Ida.

14. Informant (Address) Mrs. D W Moore Boise Ida.

15. Filed 10-20 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 92

16. DATE OF DEATH Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to 16, 1930
that I last saw her alive on Oct 15, 1930
and that death occurred, on the date stated above, at 6 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Septic Cellulis of Neck
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Septic Pulmonary
Embolus (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? Yes Date of Oct 12
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) W. H. Bradfan, M. D.
Oct 17 1930 (Address) Boise Idaho
Operation by Dr Howard

19. Place of Burial, Cremation, or Removal: Morris Hill
Date of Burial: 10-19 1930

20. Undertaker: Schreiber & McCann
Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72237

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 873
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Charles Granholm

(a) Residence. No. Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 20-1841

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hanover
(State or country) Germany

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) Germany
(State or County)

14. Informant (Address) A. Schreiber Boise, Ida

15. Filed 10-17, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 14, 1930
that I last saw him alive on Oct 13, 1930
and that death occurred, on the date stated above, at 2.30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Boise
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Urinalysis
(Signed) T. N. Bratton, M. D.
Oct 16, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill
Date of Burial 10-17 1930

20. Undertaker Schreiber & McCann
Address Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72238

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Alphonsus Hos.)
Local Registrar's No. 262
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Margarete Jean Gough

(a) Residence. No. 217 Washington St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

1123

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 19. 1924

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	9	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Ida

PARENTS

10. NAME OF FATHER Joseph Gough
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc.
12. MAIDEN NAME OF MOTHER Mary F. Toohey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wisc.

14. Informant (Address) Joseph Gough 217 Washington St. Boise

15. Filed 10-5, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 12 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1930 to Oct 12, 1930
that I last saw her alive on Oct 12, 1930
and that death occurred, on the date stated above, at 10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia + Shock

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 12
Was there an autopsy? no
What test confirmed diagnosis? Operation

(Signed) G. H. Wahle, M. D.
Oct 13, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Cy St. Johns Cemetery — Date of Burial 10/14 1930

20. Undertaker Schneider & McCain — Address Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72239

PLACE OF DEATH
County of ~~Payette~~ Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 871
(No. St Lukes Hospital Boise)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert D Dillon
(a) Residence. No. St. New Plymouth
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. — mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Mar 18 1910
7. AGE Years 20 Months 6 Days 25 If LESS than 1 day, ...hrs. or ...min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER H B Dillon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Florence Newburn
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill

14. Informant (Address) H C Dillon New Plymouth
15. Filed 10-15, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 13, 1930
that I last saw him alive on Oct 13, 1930
and that death occurred, on the date stated above, at 4:20 P. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Poliomyelitis
(duration) ...yrs. ...mos. 60 hrs.
CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.
18. Where was disease contracted if not at place of death? New Plymouth Ida
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Spinal puncture & clinical evidence
(Signed) Wm J. Drysdale, M. D.
10-15, 1930 (Address) New Plymouth Ida

19. Place of Burial, Cremation, or Removal New Plymouth Ida Date of Burial Oct 15 1930
20. Undertaker J. H. Adair Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72240

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 270
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dr Clarence E. Thayer
(a) Residence. No. 1½ mi. west of city. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

57

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Thayer

6. DATE OF BIRTH (month, day and year) 3/ 7/ 1853

7. AGE Years 77 Months 7 Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veterinary Surgeon
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springboro Ohio

PARENTS
10. NAME OF FATHER Russel Thayer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Ockley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) Mrs Henrietta Thayer, Boise, Idaho

15. Filed 10-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 7th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930 to Oct. 7, 1930
that I last saw him alive on Oct 6-1930, 19
and that death occurred, on the date stated above, at 4 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetic Gangrene & extention.
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary) Diabetes
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? St. Alphonsus
Did an operation precede death? Yes Date of Sept 15
Was there an autopsy? No
What test confirmed diagnosis? Laboratory.
(Signed) Gerald T. Nakis, M. D.
10-9-1930, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal Morris Hill cemetery
Date of Burial 10/10 1930

20. Undertaker Wm. McBratney
Address Ninth & State Boise, Idaho

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72241

PLACE OF DEATH
County of ADA
City of Boise

Registration District No. 2
Primary Registration District No. 1004 V
Local Registrar's No. 269
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161A

2. FULL NAME Douglas Rose

(a) Residence. No. Baise, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured — yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 10/10/30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or ~~still born~~ min.
) 0	0	0	4

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS

10. NAME OF FATHER Chester Rose.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Meridian, Idaho
12. MAIDEN NAME OF MOTHER Bernice Dayley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Burley, Idaho

14. Informant Chester Rose.
(Address) Baise Ida.

15. Filed 10-14, 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10/10/30, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1930, to Oct 10, 1930
that I last saw him alive on Oct 10, 1930
and that death occurred, on the date stated above, at 1:00 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Birth complicated by Pneumonia.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Premature birth. 28 hrs.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Donald T. Nokes M. D.
10-10-, 1930 (Address) Donald T. Nokes

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill cemetery	10/11/30 19
20. Undertaker	Address
Wm. McBratney	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72242

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 268
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Freda Kerrick Miller

(a) Residence. No. 2414 Woodlawn St.
(Usual place of abode.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Horatio F. Miller Jr.

6. DATE OF BIRTH (month, day and year) April 22, 1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	5	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah

PARENTS

10. NAME OF FATHER John L. Kerrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Minnie Cockerline
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant H. F. Miller Jr.
(Address) Boise, Ida.

15. Filed 10-14 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-18 1926, to 10-13- 1930, that I last saw h alive on 10-10-30 1930, and that death occurred, on the date stated above, at 5:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tuberculous Pulmonary
(duration) 6 yrs. mos. ds.
CONTRIBUTORY Tuberculous Enteritis
(Secondary)
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Indiana, Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis
(Signed) Ernest E. Rawlings M. D.
10-14- 1930 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma, Idaho	10/15/30 1930
20. Undertaker	Address
Wm. McBratney	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72243

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 V

Local Registrar's No. 267

(No.) St. Alphonsus Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Robert Vernon Smith. 10 OR

(a) Residence. No. Boise, Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 2 yrs. — mos. — ds. — How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 1- 1927

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) San Francisco
(State or country) Calif.

PARENTS

10. NAME OF FATHER Robt. O. Smith

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Colo.

12. MAIDEN NAME OF MOTHER Fern Headricks

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Boise. Ida.

14. Informant Robt O. Smith
(Address) Boise, Ida.

15. Filed 10-14 1930 W. H. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 11, 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
10-9, 1930, to Death, 19
that I last saw him alive on 10-11, 1930.
and that death occurred, on the date stated above, at 1:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

1.) Bronchopneumonia

(duration) 2 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cholera Infantum

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? at home.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) L. F. Wolcott, M. D.
10-11-30, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	10-14 1930
20. Undertaker	Address
Wm McCartney	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72244

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No.)
Local Registrar's No. 366

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry D. Smith

(a) Residence. No. 310 N. 15 St.
(Usual place of abode.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Evalena Smith

6. DATE OF BIRTH (month, day and year) July 25-1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	2	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Automobile
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marseilles, Illinois

PARENTS

10. NAME OF FATHER Eugene C Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Lucena Roath
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York

14. Informant Mrs H D Smith
(Address) 310 N 15 St Boise Idaho

15. Filed 10-14 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1930 to Oct 13 1930
that I last saw him alive on Oct 12 1930
and that death occurred, on the date stated above, at 9:30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
30 min
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Do not know.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C. M. Brayton M. D.
Oct 13 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct. 14 1930
20. Undertaker	Address
Summers & Kirke	Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72245

RECEIVED NOV 6 1930

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 265
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME David Wesley Hill
(a) Residence. No. 1711 Bannock St St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 19-1930
7. AGE Years | Months 2 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise Idaho.

PARENTS
10. NAME OF FATHER Elmer Alvah Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Agnes Foss
13. BIRTHPLACE OF MOTHER (city or town) (State or County) North Dakota

14. Informant (Address) E. A. Hill 1711 Bannock St Boise Ida
15. Filed 1[illegible], 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Octbr (Month) 13th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Octbr 12th 1930, to Octbr 13th 1930
that I last saw him alive on Octbr 12th 1930
and that death occurred, on the date stated above, at 7 a. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Volvulus of bowels (small intestines) — was a very weak infant when born — (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Flat Volvulus also when 2 days old (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bock M. D.
Octbr 14th 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Oct. 14 1930
20. Undertaker: Summers & Krebs
Address: Boise Id.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72246

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 264

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Chastine Josephene Sullivan.

(a) Residence. No. 819. N. 17 Street. St.

(Usual place of abode.)

Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White/	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Isaac. N. Sullivan.

6. DATE OF BIRTH (month, day and year) October. 6. 1845.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	0	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Willis. S. Moore.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Mary Adalaide Cotton.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Vermont.

14. Informant (Address) Isaac. N. Sullivan. 819. N. 17 Street, Boise, Idaho.

15. Filed 10-14 1930 W. N Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 19 1930, to Oct 10, 1930, that I last saw her alive on Oct 10, 1930 and that death occurred, on the date stated above, at 4.40 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma degeneration

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Senile

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Calvert M. D.

10/11 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Oct. 13. 30.
20. Undertaker	Address
Summers & Krebs.	Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

Carmon.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72247

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 263

(No. St Lukes Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lowrey Barkley

(a) Residence. No. 1 Mile South of U.P. Depot. St.

(Usual place of abode.)

Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Barkley.

6. DATE OF BIRTH (month, day and year) April. 16. 1856.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74.	5	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Druggist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER John Barkley.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Mary Barclay.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland.

14. Informant (Address) Mrs. Elizabeth Barkley. R.D. # 2. Boise, Idaho.

15. Filed 10-11-1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9th, 1930, to Oct 9th, 1930
that I last saw him alive on Oct. 9th, 1930
and that death occurred, on the date stated above, at 10 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) one or longer yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? H. C. "Tumor"

(Signed) H. C. Cannon M. D.
Oct 10th, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Oct. 11. 30

20. Undertaker: Summers & Krebs. Address: Boise, Ida

Hard tumor = gradual decline & emaciation from the time I first saw him until death

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72248

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada,
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 262

14 C

2. **FULL NAME** Thomas Merrill Fergus,

(a) Residence. No. Boise Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. — yrs. 1 mos. — ds. — How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 8, 1916

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
13	10	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work In School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Minneapolis
(State or country) Minn.

PARENTS

10. NAME OF FATHER Golden M Fergus

11. BIRTHPLACE OF FATHER (city or town) Logan,
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER Lillian Commercom

13. BIRTHPLACE OF MOTHER (city or town) Wausau,
(State or Country) Wis

14. Informant Mrs. Lillian Fergus
(Address) Boise, Idaho.

15. Filed 12-8, 1930 W. A. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 18 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19..., to ....., 19...
~~that I last saw him~~ alive on ....., 19...
~~and that~~ death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Struck by some unknown moving object, presumably an automobile, driven by some unknown person. (duration) ....yrs. ....mos. ....ds.
Chest crushed and skull fractured
CONTRIBUTORY (Secondary)
Inquest held Oct-2-1930. (duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W. McBratney, Coroner
10/2/30, 19... (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	9-21-1930
20. Undertaker	Address
H. McBratney	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72249

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise,

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 261

(No. St. Lukes Hospital, (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Jacob J. Trittenbach.

(a) Residence. No. 9 Miles, N. W. of St. Boise. (If nonresident give city or town and State.)
(Usual place of abode.)

Length of residence in city or town where death occured. 25 yrs. — mos. — ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or ~~Divorced~~ (write the word)
M.	W.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Blendina Trittenbach

6. DATE OF BIRTH (month, day and year) July 4, 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Switzerland
(State or country)

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) Not Known
(State or Country)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) Not Known.
(State or County)

14. Informant Mrs. Blendina Trittenbach
(Address) R. No 1 Boise, Idaho

15. Filed 10-8, 1930 W. J. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19..., to ....., 19.....

~~that I last saw h~~ ..... alive on ....., 19.....

~~and that~~ death occurred, on the date stated above, at about 7.20 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Auto Accident. Collision of his own car and a Union Pacific Stage. Place Boise Meridian Highway and Maple Grove Lane about 4 miles west of Boise

(duration) ..... yrs. ..... mos. ..... ds.

~~CONTRIBUTORY~~ (Secondary) Inquest held 9-23-30

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? —

(Signed) W. McBratney Coroner ~~M. D.~~

9-20-30, 19..... (Address) Boise, Idaho

19. Place of Burial, Cremation or Removal	Date of Burial
Morris Hill Cemetery	9-21-30
20. Undertaker W. McBratney	Address Boise Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72250

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 2004
(No. St. Alphonsus)
Local Registrar's No. 260
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gneal Hunter
(a) Residence. No. 1615-3rd St. North St. Nampa Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M | 4. COLOR OR RACE W | 5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4th 1929

7. AGE Years 1 | Months 3 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise
(State or country) Idaho

PARENTS

10. NAME OF FATHER Henry P. Hunter (adopted) / unknown
11. BIRTHPLACE OF FATHER (city or town) ~~Boise~~ Utah
(State or Country) adopted
12. MAIDEN NAME OF MOTHER Lola Simmons
13. BIRTHPLACE OF MOTHER (city or town) Mexico
(State or County)

14. Informant Mrs. Harry Hunter
(Address) Nampa, Idaho

15. Filed 10-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930, to Oct. 1, 1930, that I last saw h[illegible] alive on Oct 1, 1930 and that death occurred, on the date stated above, at 9:20 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos. 4 ds.
CONTRIBUTORY (Secondary) Epidemic Entero-Colitis
(duration) 0 yrs. 0 mos. 11 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Post-mortem findings

(Signed) Harmon A. Freeland M. D.
Oct. 2, 1930 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Nampa, Ida. | Date of Burial: 10-5 1930
20. Undertaker: Wm. Talley | Address: Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72251

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 259
(No. St. Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel B. Cunningham Cranston 1010

(a) Residence. No. 906 Harrison Blvd St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Earle A. Cranston

6. DATE OF BIRTH (month, day and year) July 1st 1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	2	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER William Cunningham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Un Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) W. W. Cranston 1009 ns 6-Boise

15. Filed 10-1, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1930 to Sept 28, 1930 that I last saw h[illegible] alive on Sept 28, 1930 and that death occurred, on the date stated above, at 12 M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Right Side.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dementia Praecox,
Insanity (duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? At Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Gross & Microscopic
(Signed) Gerald T. Nokes, M. D.
Sept 29, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Baker, Oregon	Oct. 1 1930
20. Undertaker	Address
Schreiber & W. Co.	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72252

PLACE OF DEATH

County of Ada

City of Grand View

Registration District No. 74

Primary Registration District No. 2151

Local Registrar's No. 60

(No.) 46

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Minnie Alice Hickman

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a. If married, widowed, or divorced
(or) WIFE of John Hickman

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	3	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leavenworth, Kansas

PARENTS

10. NAME OF FATHER Jacob Langley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mississippi

12. MAIDEN NAME OF MOTHER Pauline Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mississippi

14. Informant Mrs. Wm. Rogers

(Address) Mt. Home

15. Filed Nov. 1st, 1930 W. J. Eikenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 18th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6th, 1930, to Oct. 18th, 1930

that I last saw her alive on Oct. 18th, 1930

and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus and rectum

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Eikenbeck, M. D.

Oct. 18, 1930 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home	Oct. 20th 1930
20. Undertaker C. G. Zacher	Address Mt. Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 5 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adams

City of Indian Valley

Registration District No.

Primary Registration District No.

(No. ..... St.)

File No. 72253

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Shirley June Courtright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Oct (Month) 28 (Day) 1930 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... No

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Indian Valley Ida

10. NAME OF FATHER Cherty Courtright

11. BIRTHPLACE OF FATHER (State or Country) Midvale Ida

12. MAIDEN NAME OF MOTHER Leona Macomb

13. BIRTHPLACE OF MOTHER (State or Country) Midvale Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) x Mrs Riley Harris

(Address) Mill Port Ore

15. Filed 10-31-30. 191

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1930 (Year) 159B

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1930, to Oct 29 1930, that I last saw her alive on Oct 29 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Malformation of the heart
Foramen Ovale not closed.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. 1 ds.

(Signed) G. F. Hunt D.C. ~~M. D.~~

..... 19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Ida

DATE OF BURIAL: Oct 30 1930

20. UNDERTAKER: J A Hudelson

ADDRESS: Cambridge Ida

SYMS - YORK CO., PTRS. & SDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72254

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5927
(No. St. Marie Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME H. Edward Taylor
(a) Residence. No. St. Marie Hotel St. 90
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 15, 1872

7. AGE Years 58 Months Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) St. Marie Hotel
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portland Oregon

PARENTS
10. NAME OF FATHER Phelix P. Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Alice A. Potter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinoise

14. Informant (Address) Edward P. Taylor

15. Filed 10-19, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on Oct - 17, 1930
and that death occurred, on the date stated above, at about 8 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Man was dead when I arrived at hotel - death presumably from heart trouble?
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) H. C. Dawson M. D.
10/18, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal ~~Pocatello Idaho~~ Nevada City Calif. Date of Burial Oct 19 1930

20. Undertaker H. L. McHan Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72255

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5926

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Joseph Thomas Morgan
(a) Residence. No. 1140 N. Hayes St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) June 15-1930

7. AGE Years Months 4 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS
10. NAME OF FATHER James R. Morgan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Ethel Keating
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant James R. Morgan
(Address) Pocatello Idaho

15. Filed 10-18, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 15 - 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/14, 1930, to 10/15, 1930
that I last saw him alive on 10/15, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Sinus thrombosis
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) ? ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
10/18, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Oct 16 1930

20. Undertaker Schumacher & Beasley Inc
Address City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72256

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 08
Primary Registration District No. 2161
Local Registrar's No. 5925
(No. 1390 2nd)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Olive Mae Wells

(a) Residence. No. 1390 2nd St. 112
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19th 1930

7. AGE: Years | Months: 4 | Days: 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello Idah

PARENTS

10. NAME OF FATHER: Fred Wells
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Anna Orton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho

14. Informant: Mrs Anna Wells
(Address) Pocatello Idaho

15. Filed 10/13, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Gastro Enteritis
Baby had been sick greater part of time since Birth
... (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Arthur W Hall Coroner M.D.
..., 19... (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	10/13th 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED NOV 14 1930

DO NOT WRITE IN THIS SPACE
State File No. 72257

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2861 Local Registrar's No. 5924

(No.) Rear of 318 South Second Ave. Poca.

(If death occurred in a hospital or institution, give its name instead of street and number.)

Poca

2. **FULL NAME** Lena M. Hicks

(a) Residence. No. 318 South Second Ave. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Widow of John B. Hicks

6. DATE OF BIRTH (month, day and year) January 16, 1870.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	8	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Zenith Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Mrs. Edna Mathers
(Address) 318 South Second Ave. Poca., Ida.

15. Filed 10/14/30. 19.... J. R. Summers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 12, (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 '30 to Oct 12 1930
that I last saw her alive on Oct 12 1930
and that death occurred, on the date stated above, at 10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. W. Brotherton M. D.

10/13/30. 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. Date of Burial: 10/15/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72258

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No. 454 So Garfield)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5922

84 B

2. FULL NAME Jessie Weir

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

~~3. SEX~~ Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Thomas Weir

6. DATE OF BIRTH (month, day and year) Nov 22 - 1880

7. AGE Years 49 Months 8 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Thomas Henderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jessie Henderson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Thomas Weir

(Address) Rockland Idaho

15. Filed 10-11, 1931 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-9, 1930, to 10-10, 1930

that I last saw her alive on 10-9, 1930

and that death occurred, on the date stated above, at 4 a.m. m.

The CAUSE OF DEATH* was as follows: Pulmonary edema

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocarditis

Chiropractic treatments

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [signature], M. D.

10/11, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rockland Ida

Date of Burial 10/14 1930

20. Undertaker Schumacher & Beasley Inc

Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72260

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5920
(No. Pocatello General Hospital 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ross A Barrus.
(a) Residence. No. Burley Idaho St. Burley Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) June 23-1913
7. AGE Years 17 Months 4 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Burley Idaho

PARENTS
10. NAME OF FATHER O. L. Barrus.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Maud Cook
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) Golden Barrus.
15. Filed 10-4, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 9 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 9, 1930
that I last saw him alive on Ex Oct 8, 1930
and that death occurred, on the date stated above, at 5 A m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Brain abscess
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Acute Ethmoiditis
(duration) yrs. 2 mos. ds.
18. Where was disease contracted if not at place of death? Salmon, Idaho
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C W Pond, M. D.
Oct 9, 1930 (Address) Kane Bldg.

19. Place of Burial, Cremation, or Removal Burley-Idaho Date of Burial 19
20. Undertaker H. L. McKan Address 217 So Arth

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72261

Local Registrar's No. 5919

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 634 W. Greely)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Angelita Rodriguez

(a) Residence. No. 634 W. Greely St. 1010

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE:

5. Single, Married, Widowed, or Divorced (write the word): Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 15-1930

7. AGE — Years: | Months: 4 | Days: 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or Country): Pocatello Idaho

PARENTS

10. NAME OF FATHER: Pete Rodriguez

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Adelena Chacon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Pete Rodriguez
(Address) 634 W. Greely

15. Filed 10/9, 1930. J. H. Tunney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 9th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-4, 1930, to 10-9, 1930
that I last saw h.. alive on 10-9, 1930
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) ..... yrs. ..... mos. ? ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) ..... yrs. ..... mos. 21 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. H. Tunney, M. D.
10-9, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Oct 9 1930

20. Undertaker: Schumacher Moseley Inc — Address: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
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RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72262

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5918
(No. Pocatello House)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME J. P. Welker
(a) Residence No. 305 E. Center St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 53 Months Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Line man
(b) General nature of industry, business, or establishment in which employed (or employer) Electrical
(c) Name of employer Idaho Power

9. BIRTHPLACE (city or town) (State or country) Phenoix Arizona

PARENTS
10. NAME OF FATHER John Eler Welker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Phenoix Arizona
12. MAIDEN NAME OF MOTHER Grace Rouche
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Karpville Utah

14. Informant (Address) C. C. Welker

15. Filed 10-8, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-11, 1930, to 7-1-, 1930.
that I last saw him alive on 7-1-, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Thr. Cholecystitis
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical [illegible]
(Signed) [illegible] M. D.
10-8, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal St. Anthony
Date of Burial 19

20. Undertaker H. L. McHan
Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72263

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5917
(No. Pac Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

174 C

2. FULL NAME Judson L. Brinkley
(a) Residence. No. 228, So. Hayes St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day, and year) Aug 28, 1915
7. AGE Years 15 Months 1 Days 7 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sterling Colo.

PARENTS
10. NAME OF FATHER: Wm. J. Brinkley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tennessee
12. MAIDEN NAME OF MOTHER: Elaise Cogswell
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Arkansas

14. Informant (Address): Wm. J. Brinkley Pocatello Idaho
15. Filed Oct 4, 1930 H. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 4, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 4, 1930
that I last saw him alive on Oct 4, 1930
and that death occurred, on the date stated above, at 3 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Basillas skull fracture
automobile accident (duration) ..... yrs. ..... mos. 3 hrs. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 10-4-30
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) W. W. Brothers M. D.
10-5, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal: Pocatello Ida
Date of Burial: Oct 5 1930
20. Undertaker: McHan Undt Co
Address: Pocatello

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72264

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock

City of Blaser

Registration District No. .....

Primary Registration District No. 2161 Local Registrar's No. 291

(No. Ranch at Blaser Idaho.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Etta Sophia Byington

(a) Residence. No. Blaser, Idaho. St. .....

(Usual place of abode.)

Length of residence in city or town where death occured. 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wife of Charles N.Byington

6. DATE OF BIRTH (month, day and year) September 1, 1879

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	0	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mill-Creek, Utah.

PARENTS

10. NAME OF FATHER Robert Smithies

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Scott

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nebraska

14. Informant (Address) Charles N. Byington Blaser, Idaho

15. Filed 9/29/30. 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 27, (Day) 1930. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930 to Sept 23, 1930

that I last saw h[illegible] alive on Sept 23, 1930 17 hrs

and that death occurred, on the date ~~stated above~~, at 6 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Mitral Lesion of Heart

..... (duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) Genuine Anasarka.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) F. Smith, M. D.

9/27/30., 19..... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Annis Cemetery Annis, Idaho.	9/30/30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72265

PLACE OF DEATH
County of Bannock
City of Pocatello

CERTIFICATE OF DEATH
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5916
(No. Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Infant John W. Wagner
(a) Residence. No. 322 So Lincoln St. Blackfoot Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 0 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of none
6. DATE OF BIRTH (month, day and year) Sept. 4-1930
7. AGE Years | Months | Days 0 | If LESS than 1 day, hrs. or None min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer None
9. BIRTHPLACE (city or town) (State or country) None

PARENTS
10. NAME OF FATHER John W. Wagner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cedar Rapids Iowa.
12. MAIDEN NAME OF MOTHER Doris E. Dunn
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Blackfoot Idaho

14. Informant (Address) John W. Wagner Pocatello Idaho
15. Filed 9-4-30 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 4 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1930 to Sept 4 1930
that I last saw him alive on Stillborn 19
and that death occurred, on the date stated above, at m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Stillborn.
Due to albumina.
of mother.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
9-4, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal Blackfoot Idaho
Date of Burial Sept. 4 1930
20. Undertaker H. L. McHan
Address Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

REC NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72266

PLACE OF DEATH
County of Bannock
City of Virginia

Registration District No. 83
Primary Registration District No. 2160
(No.) Local Registrar's No. 15

(If death occurred in a hospital or institution, give its name instead of street and number.)

94

2. FULL NAME Elizabeth Tyrene Juchan

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Juchan

6. DATE OF BIRTH (month, day and year) Sept. 23-1841

7. AGE Years 89 Months Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sailing Vessel "Tyrene"

PARENTS
10. NAME OF FATHER Martin Littlewood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Muir
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant J J Juchan
(Address) Virginia Idaho

15. Filed Nov. 12, 1930. Mary C. Coffin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 7, 1930
that I last saw him alive on Oct - 7 - 1930
and that death occurred, on the date stated above, at 2:10 P.m.
The CAUSE OF DEATH* was as follows: Hydrocephalus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) None known

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D. J. Hartigan, M. D.
10 - 7 - 1930 (Address) Downey, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Smithfield Utah
Date of Burial Oct. 8 1930

20. Undertaker J. Guy Benson
Address Malad Ida

Print is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 14 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ....., ... St.)

File No. 72267

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept - 18 - 1930 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 9 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Downey, Idaho

10. NAME OF FATHER: Lloyd L. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Preston, Idaho

12. MAIDEN NAME OF MOTHER: Zelpha Whitaker

13. BIRTHPLACE OF MOTHER (State or Country): Downey, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd L. Jensen

(Address) Downey, Idaho

15. Filed Nov. 12 1930 Mary C. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept - 19 - 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1930, to Sept - 19 - 1930, that I last saw him alive on Sept - 19 - 1930; and that death occurred on the date stated above, at 9.00 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartigsen M. D.

9-30 1930. (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72268

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. **FULL NAME** Ralph LaMar Gilbert

(a) Residence. No. Pocatello, Idaho. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 3, 1930.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	Eight	Four	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER W. T. Gilbert

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Galbraith

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant W. T. Gilbert
(Address) Pocatello, Idaho.

15. Filed 11/8/30., 19.....

J. R. Young
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 7, (Day) 1930., 19.. (Year)

17. I HEREBY CERTIFY, That I attended deceased from
11/5, 1930, to 11/7, 1930
that I last saw h~~e~~ alive on 11-7, 1930
and that death occurred, on the date stated above, at 11 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Streptococcus Throat.
(duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? home -
Did an operation precede death? no. Date of —
Was there an autopsy? no -
What test confirmed diagnosis? Laboratory -

(Signed) J. R. Young, M. D.
11/8/30., 19.. (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery, Pocatello, Idaho. Date of Burial: 11/8/30. 19

20. Undertaker Arthur W. Hall Address Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72269

PLACE OF DEATH

County of Bannock

City of Pocatello Idaho

Registration District No. 28

Primary Registration District No. 2161

(No. St. Anthony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5935

92

2. FULL NAME Mrs. John (Charlotte) Spritzer

(a) Residence. No. Blackfoot Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Spritzer

6. DATE OF BIRTH (month, day and year) Apr. 29, 1856

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	6	11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mother (Home Keeper)

(b) General nature of industry, business, or establishment in which employed (or employer) Not Employed

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fort Bridger Wyoming

PARENTS

10. NAME OF FATHER George Renensland

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Strausburg ~~Hanover~~ Germany

12. MAIDEN NAME OF MOTHER Charlotte Fox

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hanover Germany

14. Informant J R Spritzer
(Address) Blackfoot Idaho

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/31, 1930, to 11/9, 1930

that I last saw her alive on 11/9, 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Coronary embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystolany

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot Ida

Did an operation precede death? Yes Date of 10/31/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

11/10, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grove City Cemetery — Date of Burial Nov 12 1930

20. Undertaker E J Peck — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72271

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

175

2. FULL NAME Chloe Ann Ashton

(a) Residence. No. Tupper Appt's 255 So. Garfield St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May. 27. 29

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
I	5	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Murray, Utah

PARENTS

10. NAME OF FATHER: Milton P Ashton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City, Utah
12. MAIDEN NAME OF MOTHER: Ann Howe
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Murray Utah

14. Informant (Address) Milton P. Ashton
Tupper App's 255 So. Garfield

15. Filed 11/1, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November I, 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 1, 1930
that I last saw her alive on Oct 30 PM, 1930
and that death occurred, on the date stated above, at 4 15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Food poision
Child had eaten large quantity of Pecan nuts
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Somach & Bowell Washing
(Signed) O. F. Call, M. D.
11-1-, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Murray Utah Cemetery
Date of Burial: Nov. 2, 1930

20. Undertaker: Arthur W. Hall
Address: Pocatello Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D NOV 14 1930

DO NOT WRITE IN THIS SPACE
State File No. 72272

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2-161
Local Registrar's No. 5923
(No. 624 East Whitman St. Poca., Ida.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Harriett Ellen Hadley

(a) Residence. No. 624 East Whitman St. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wife of James R. Hadley

6. DATE OF BIRTH (month, day and year) July 16, 1843.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Herman Coltrin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) James R. Hadley 624 East Whitman St. Poca., Ida.

15. Filed 11/6/30. 19 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 5, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1, 1930, to 11/5, 1930
that I last saw h[illegible] alive on 11/4, 1930
and that death occurred, on the date stated above, at 9 9 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

3

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lagrippe

(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.
11/6/30. 19 (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oxford, Idaho.	11/ 7/ 30. 19
20. Undertaker Arthur W. Hall	Address Pocatello

Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72273

NOV 14 1930

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 3932
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME William Gilbert

(a) Residence. No. Truck Farm North of Poca., St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Amanda Atkinson

6. DATE OF BIRTH (month, day and year) April 5, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	6	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Brigham City, Utah.

PARENTS

10. NAME OF FATHER William Gilbert
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wales

14. Informant (Address) Mrs. Arch Stoddard, Pocatello, Idaho.

15. Filed 10/1/30., 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 1930, to Oct 31, 1930
that I last saw him alive on Oct 31, 1930
and that death occurred, on the date stated above, at 3:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bilateral Bronchopneumonia

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease
(duration) Few yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) William T. Howard M. D.
10/31/30., 19.... (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	Nov. 2, 30
20. Undertaker Arthur W. Hall	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72274

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock.
City of McCammon

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5931
(No. McCammon, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** Leda Elizabeth Gittins.

(a) Residence. No. McCammon, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April.19. 1915.

7. AGE: 15 Years | Months: 6 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School-girl.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) McCammon, Idaho.

PARENTS

10. NAME OF FATHER J.T.Gittins.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Clara Blousett.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Fairview, Utah.

14. Informant (Address) J.T.Gittins (father) McCammon, Idaho.

15. Filed 10/30, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct.28. (Month) (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3, 1930, to Oct 27, 1930
that I last saw her alive on Oct 27, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
..... (duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O Fleau, M. D.
Oct. 30., 1930. (Address) Pocatello, Ida.

19. Place of Burial, Cremation, or Removal: McCammon, Idaho | Date of Burial: Oct.30.1930

20. Undertaker: Arthur W.Hall | Address: Poca.Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72275

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5930
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kameji Okamura
(a) Residence. No. Pocatello - R. F. D. #1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. Okamura

6. DATE OF BIRTH (month, day and year) April-8-1887

7. AGE: Years 43 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farming
(c) Name of employer: None

9. BIRTHPLACE (city or town) (State or country): Japan

PARENTS

10. NAME OF FATHER: Shakazigi-Okamura
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Shika Okamura
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Japan

14. Informant (Address): Siachi Yokota Savoy Cafe Pocatello Idaho

15. Filed 10/30, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Crushing injury to chest & abdomen, Broken Back
Run over by truck Accidental
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Arthur W Hall. Coroner ~~M. D.~~
10/30, 1930 (Address) Pocatello.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho | Date of Burial: 10-2 1930

20. Undertaker: H. L. McHan | Address: Poca. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72276

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5929
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Fred McKinley Rhodes
(a) Residence. No. 530 West Lublet Ave. St.
(Usual place of abode.) Red. (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or WIFE of~~ Husband of Katherine Rhodes

6. DATE OF BIRTH (month, day and year) June-16-1895

7. AGE Years 35 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work R. R. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer
(c) Name of employer O. L. L. Co.

9. BIRTHPLACE (city or town) (State or country) Thompson Arkansas

PARENTS
10. NAME OF FATHER J. C. Rhodes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Rusky Hanington
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mrs. Katherine Rhodes.

15. Filed 10-22, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 22. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-17, 1930, to 10-22, 1930
that I last saw him alive on 10-22, 1930
and that death occurred, on the date stated above, at 7 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis - Gangrenous
Appendicitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No -
Did an operation precede death? yes Date of 10/17-30
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. R. Young M. D.
10-22, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Mt. View Cemetery Date of Burial 10-24 1930
20. Undertaker H. L. McHan 163 Address 217 So. Arth.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 14 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72277

Local Registrar's No. 5928

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
(No. 734 N. Grant)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME James Edward Hulihan

(a) Residence. No. 734 N. Grant St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bridget Hulihan

6. DATE OF BIRTH (month, day and year): April 19th 1859

7. AGE: Years 71 | Months 6 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Patrick Hulihan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Johanna Flaherty
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Mrs James E. Hulihan
(Address) Pocatello Idaho

15. Filed 10-22, 1930 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Oct 21, 1930
that I last saw ~~born~~ alive on Oct 21, 1930
and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
Chronic myocarditis
(duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Brothers M. D.
10-23, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Salem Ohio — Date of Burial: Oct 27 1930

20. Undertaker: Schumacher & Beasley — Address: City

Due

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72278

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 152

113

2. FULL NAME Mary Thornick
(a) Residence. No. Bloomington
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2, 1929

7. AGE: 1 Years | Months: 6 | Days: 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Cecil Leroy Thornock
11. BIRTHPLACE OF FATHER (city or town) Bloomington (State or Country) Bear Lake county Idaho
12. MAIDEN NAME OF MOTHER Fern Alice Quinton
13. BIRTHPLACE OF MOTHER (city or town) Bloomington (State or Country) Bear Lake County Idaho

14. Informant
(Address)

15. Filed 10/31, 1930 Mrs. J. S. Skinner Registrar
Per. Mrs. Arthur Hess.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10-29 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-27, 1930, to 10-29, 1930
that I last saw her alive on Oct 27, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Gastro-enteritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
10-31, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Bloomington | Date of Burial: Oct 31 1930

20. Undertaker: John Hulme | Address: Bloomington Idaho

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72279

PLACE OF DEATH
County of Bear Lake
City of Bloomington

Registration District No. 53
Primary Registration District No.
Local Registrar's No. 157-A

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

20-B

2. FULL NAME Delson James Nelson

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 19, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Lovern Nels Nelson
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Eudora Christianson
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant Lovern Nelson
(Address)

15. Filed 10/31, 1930 Mrs. J. F. Plummer
Registrar
Per. Mrs. Arthur Hess

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19..., to —, 19...
that I last saw h— alive on —, 19...
and that death occurred, on the date stated above, at ...m.
The CAUSE OF DEATH* was as follows:
Cause Unknown but Natural- No attending Physician sick few hrs
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C O Moore M. D.
10/29, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Bloomington, Ida.	10/31, 1930
20. Undertaker	Address
John Hulme	Bloomington Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96 —200 d

RECEIVED NOV 6 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72281

1 PLACE OF DEATH
County Benewah State Idaho Registered No.
Township Tensed, Idaho or Village Tensed, Idaho or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Mésol 90

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	Indian	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pete Hockeo

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
About	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Coeur d'Alene Reserve
(State or country) Kootenai Idaho

PARENTS

10 NAME OF FATHER Bonaventure Schezi

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Coeur d'Alene Reserve

12 MAIDEN NAME OF MOTHER Julia Mary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Coeur d'Alene Reserve

14 Informant John Davenport
(Address) DeSmet, Idaho

15 Filed Oct. 4, 1930 John Post REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Oct 2, 1930,
that I last saw alive on Oct 2, 1930,
and that death occurred, on the date stated above, at 1 PM m.
The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. A. Nelson, M. D.
10/4 1930 (Address) Reyton Wn

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
DeSmet, Idaho	Oct. 4, 1930
20 UNDERTAKER	**ADDRESS**
C. L. Schuleund	Tekoa, Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72282

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

108

2. FULL NAME Owen B Felton

(a) Residence. No. ..... St. Malden Wash
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Susan H Felton

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Conductor on RR
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: C-M, St P. & P. RR Co

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Susan H Felton
(Address) Malden Wash

15. Filed Nov 6, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 17, 1930, to October 25, 1930
that I last saw him alive on October 24, 1930.
and that death occurred, on the date stated above, at 8 A. m.
The CAUSE OF DEATH* was as follows:
Coronary Occlusion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D. Cornwall, M. D.
October 25, 1930 (Address) St. Maries, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash
Date of Burial: Oct 28 - 1930

20. Undertaker: Geo. E. Mitchell
Address: St. Maries

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72283

PLACE OF DEATH
County of Clearwater
City of Emida

Registration District No. 22
Primary Registration District No. 2079
Local Registrar's No. 29

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alfred Johnson
(a) Residence. No. Ranch - Emida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 18 - 1881

7. AGE	Years	Months	Days	If LESS than 1 day,
	49	8	7	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10. NAME OF FATHER John Back
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Helena not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant W W Johnson
(Address) Emida Ida

15. Filed Nov 6, 1930 Walter Bokerg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-5, 1930, to 10-23, 1930
that I last saw h[illegible] alive on 7-5, 1930
and that death occurred, on the date stated above, at 2 p. m.
The CAUSE OF DEATH* was as follows:
Progressive muscular Atrophy
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A G Eske, M. D.
10/24, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmida Ida	Oct 26 1930
20. Undertaker	Address
Geo E Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 10 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Denewah
City of St. Maries, Idaho

Registration District No. 32
Primary Registration District No. 2049
(No. St. Maries Hospital St.)

File No. 72284
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ed O'Connell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. unknown (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE about 60 yrs .....Yrs.....Mos.....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Logger
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) unknown

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. W. Fountain
(Address) St. Maries, Ida.

15. Filed Nov 6 1930 Walter Boberg
Local Registrar

MEDICAL CERTIFICATE OF DEATH 43

16. DATE OF DEATH Oct (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1930, to Oct 23 1930, that I last saw him alive on Oct 23 1930, and that death occured on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the oesophagus

.....(Duration) .....Yrs. 6 mos. — ds.

Contributory (Secondary) —

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. A. Collins M. D.
10/23 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. Hosp. 29 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Unknown
Former or usual residence Operated 10/21/30 - Gastrostomy

19. PLACE OF BURIAL OR REMOVAL St. Maries, Ida
DATE OF BURIAL 10/25 1930

20. UNDERTAKER Geo. E. Mitchell
ADDRESS St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72285

PLACE OF DEATH
County of Benewah
City of St. Maries, Idaho
Registration District No. 32
Primary Registration District No. 2029
Local Registrar's No. 27
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Albert R. Merry
(a) Residence. No. ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE:
5. Single, Married, Widowed, or Divorced (write the word): Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE — Years: 69 | Months: 6 | Days: 5 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Timberman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kansas

PARENTS
10. NAME OF FATHER: R T Merry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Walter A Merry
(Address): St Maries Ida
15. Filed Nov 6, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 7, 1930, that I last saw him alive on Oct 7, 1930, and that death occurred, on the date stated above, at 2:50 A m.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) No contributory
(duration) ..... yrs. ..... mos. ..... ds.
Cause Known
18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam.
(Signed) C A Robins, M. D.
10/10, 1930 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	Oct 14 1930
20. Undertaker	Address
Geo E Mitchell	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72286

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 137
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 147

2. FULL NAME ANTONE DYMACK

(a) Residence. No. ... St. Idaho Falls Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10. NAME OF FATHER: Mike Dymack

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12. MAIDEN NAME OF MOTHER: Mary Young

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14. Informant: Harold Goldsworthy Attendant
(Address): Blackfoot, Idaho.

15. Filed Oct. 9, 1930 Mrs Halen E Cabrie
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 8th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19th 1930, 19... to Oct 8th 1930, 19...
that I last saw him alive on Oct 7-1930, 19...
and that death occurred, on the date stated above, at 4:30A m.
The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo Williams, M. D.
Oct 8th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ross Hill Cem Idaho Falls	Oct 11 1930

20. Undertaker: E J Funk — Address: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72288

NOV 10 1930

PLACE OF DEATH

County of Bingham

City of Shelley

Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 145

(No. 162)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lloyd Crooks

(a) Residence. No. Shelley, Ida. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 2, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shelley, Ida.

PARENTS

10. NAME OF FATHER Donald J. Crooks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) American Fork Utah.

12. MAIDEN NAME OF MOTHER Edith Oler

13. BIRTHPLACE OF MOTHER (city or town) (State or County) American Fork Utah.

14. Informant Donald J. Crooks
(Address) Shelley, Ida.

15. Filed Oct-6, 1930 Mrs Helen E. Calvin Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-2, 1930, to 10-5, 1930

that I last saw him alive on 10-5, 1930

and that death occurred, on the date stated above, at 8:55 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Immediate Jaundice,
Probably Atelexia of
Common bile duct

(duration) 6 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Edwin Cyffers, M. D.

10-6, 1930 (Address) Shelley

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelley, Ida.	Oct. 6 1930
20. Undertaker	Address
Jack A. Woods	Idaho Falls, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72289

Local Registrar's No. 144

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 121
Primary Registration District No. 7194
SOUTH IDAHO INSANE ASYLUM
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

51

2. FULL NAME Margaret Badger

(a) Residence. No. ..... St. Twin Falls Co
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	Cauc.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Minnie Hayes Att.
(Address) Blackfoot, Ida.

15. Filed Oct. 6, 1930 Mrs Nalin E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5th, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..., to Oct 5th 1930, 19...
that I last saw her alive on Oct 5th 1930, 19...
and that death occurred, on the date stated above, at 10 A m.
The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Oct 5th, 1930 (Address) Blackfoot

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Cemetery	Oct 7th 1930

20. Undertaker E. J. Funk — Address Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72290

RECEIVED NOV 10 1930

PLACE OF DEATH
County of Bingham
City of Blackfoot

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2174 Local Registrar's No. 143
(No.) 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James G Browning
(a) Residence. No. St. Blackfoot Rt #1
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Amanda Browning

6. DATE OF BIRTH (month, day and year) November 3, 1862

7. AGE Years 67 Months 11 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden, Utah

PARENTS
10. NAME OF FATHER James G. Browning
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Ann Wood
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) James G. Browning Idaho Falls, Idaho

15. Filed Oct. 5, 1930 Mrs Valerie Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 4 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 4, 1930
that I last saw him alive on Oct 3, 1930
and that death occurred, on the date stated above, at 9-30a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
10/5, 1930 (Address) Blackfoot, Ida

19. Place of Burial, Cremation, or Removal Annis Idaho Date of Burial Oct 6 1930

20. Undertaker Jack A. Wood Address Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72293

PLACE OF DEATH

County of BINGHAM

City of BLACKFOOT

Registration District No. 121

Primary Registration District No. 3194

Local Registrar's No. 142

(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME MARGARET SERFAS

(a) Residence. No. ..... St. ..... remont County
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER ---

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER ---

13. BIRTHPLACE OF MOTHER (city or town) ---
(State or Country)

14. Informant Sylvia Paesl, Aut.
(Address) Blackfoot, Ida.

15. Filed Oct. 6, 1930 Mc Nalen E Caton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 3rd, 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
Oct 1st 1927, 19 Oct 3rd 1930, 19
that I last saw her alive on Oct 3rd, 1930, 19
and that death occurred, on the date stated above, at 11:50 A m.
The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. E. Williams, M. D.

Oct 3rd, 1930 (Address) Blackfoot,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida. | Date of Burial 19

20. Undertaker E. J. Peck | Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72293

PLACE OF DEATH
County of Bingham
City of Blackfoot.
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 140
(No.) 188 C
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Valdemar S. Jensen,

(a) Residence. No. Rose R.F.D. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edna Jensen,

6. DATE OF BIRTH (month, day and year) April, 15, 1897.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Mauris Jensen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Marie Sorsenson,

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Marie Jensen
(Address) Pocatello Ida

15. Filed Oct 6, 1930 Mc Helen E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 2, 1930
that I last saw him alive on Oct 2, 1930
and that death occurred, on the date stated above, at 10:20a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Injury to Chest auto accident
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —,
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W W Beck, M. D.
10/3, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or ~~Removal~~	Date of Burial
Blackfoot, Ida.	10-5-30 19

20. Undertaker	Address
Modern Mortuary,	Blackfoot. Ida

Current Complete

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE Jul. 1930
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72294

RECEIVED NOV 10 1930

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft. Hall Reservation Registration District No. 121

City of Ft. Hall, Idaho. Primary Registration District No. 2194-R.

Local Registrar's No. 139

(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

22

2. FULL NAME Leon Perry

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Shoshone Ind. 7/8

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day and year) 12- 13- 24.

7 AGE: Years 6 | Months 5 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Ft. Hall Reservation

PARENTS

10 NAME OF FATHER Lynn Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wind River Reservation

12 MAIDEN NAME OF MOTHER May tyboats

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washakie, Utah

14 Informant Nesbit Weeks
(Address) Ft. Hall, Idaho.

15 Filed Oct. 20, 1930 Mrs Helen E. Caterie Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1930 19..... (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1930, 19....., to Jul. 6, 1930, 19.....,
that I last saw him alive on July 6, 193, 19.....,
and that death occurred, on the date stated above, at 3:00 m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis

15, Days
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) Henry P. Heeler, M. D.
....., 19..... (Address) Ft. Hall. Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Portneuf Cemetery, Ft. Hall Res'vn, 7-8-30

Date of Burial: 19

20. Undertaker: Agency Carpenter Ft. Hall, Idaho.

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RE[illegible] NOV 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72295

PLACE OF DEATH

County of BINGHAM
City of BLACKFOOT

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2144
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 158

45

2. **FULL NAME** MARY HAYNES

(a) Residence. No. ..... St. CHALLIS, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 34 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word.): SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 78 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (city or town) (State or County): "

14. Informant (Address): Minnie Hayes, Att. Blackfoot, Ida.

15. Filed Oct. 30, 1930 Mrs Helen E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: OCT 30, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..., to Oct 30, 1930, 19...
that I last saw her alive on Oct 30th, 1930, 19...
and that death occurred, on the date stated above, at 9:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Intestines

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Age

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo. Williams, M. D.
Oct 30, 1930 (Address) Blackfoot Ida

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Asylum Cemetery
Date of Burial: Oct 30 1930

20. Undertaker: Acting Marion Clark
Address: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... NOV ... 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72296

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. Beck Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 157

189

2. FULL NAME Paul O. Frasure
(a) Residence. No. R.F.D. 3 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: -----

6. DATE OF BIRTH (month, day and year): March 17, 1925

7. AGE: Years 5, Months 7, Days 7. If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bannock County Idaho.

PARENTS

10. NAME OF FATHER: Robert Frasure
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Elsie Bentley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Robert Frasure
(Address): Black Foot R F D 3

15. Filed Oct. 26, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Oct 24, 1930
that I last saw him alive on Oct 24, 1930
and that death occurred, on the date stated above, at 10:20 P m.
The CAUSE OF DEATH* was as follows:
Peritonitis with Paralytic Ileus
(duration) \ yrs. \ mos. 3 ds.
CONTRIBUTORY (Secondary) Ruptured bowel from kick by horse
(duration) \ yrs. \ mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Oct 22
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
Oct 26, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Morland Idaho
Date of Burial: Oct. 26 1930

20. Undertaker: E.T.Peck
Address: Blackfoot

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72297

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. South Shelling. 440 So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 156
118 B

2. FULL NAME Ida Tipton Hayes
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: T. A. Hayes

6. DATE OF BIRTH (month, day and year): Sept 13-1857

7. AGE: Years 73 | Months 1 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Cleveland Tenn

PARENTS
10. NAME OF FATHER: J. C. Tipton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Blount County, Tennessee
12. MAIDEN NAME OF MOTHER: Elizabeth Sharon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nashville Tenn

14. Informant: T. Alby Hayes
(Address): Blackfoot, Idaho

15. Filed Oct. 25, 1930 Mrs Walter E. Catrie, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 10 (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Oct. 23, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 7.15 m.
The CAUSE OF DEATH* was as follows:
Obstruction of bowels
..... (duration) ..... yrs. ..... mos. 10 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) F. C. Mitchell M. D.
Oct. 25, 1930 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Grove City Cemetery | Date of Burial: Oct 26 1930

20. Undertaker: E. J. Peck | Address: Blackfoot Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

REGISTERED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72298

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 15-5

70

2. FULL NAME TERESA M. GILL

(a) Residence. No. IDAHO INSANE ASYLUM St. Boise Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. / mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
FEMALE	WHITE	MARRIED

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of HENRY T. GILL

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work HOUSEWIFE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) BOISE, IDAHO

PARENTS

10. NAME OF FATHER Godfred Rhodes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Grace Wadkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Grace A Clippinger R.N.
(Address) Blackfoot Ida

15. Filed Oct. 24, 1930 Mrs Nalus E. Tatum Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1930, 19 to Oct 23 1930, 19
that I last saw her alive on Oct 23rd 1930, 19
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Exophthalmis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? None
What test confirmed diagnosis?

(Signed) Geo. Williams, M. D.
Oct 23 1930, 19 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Oct 26 1930
20. Undertaker Boise Mortuary	Address Boise Ida
Schreiber & McCann	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72300

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 103

119

2. FULL NAME Hazel Alice Moon
(a) Residence. No. Blackfoot RFD 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 22 1930

7. AGE Years 0 Months 8 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Oscar Moon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Maude Baker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colo

14. Informant Oscar Moon
(Address) Blackfoot

15. Filed Oct. 18, 1930 Wm Hales E. Cater Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ Investigated death
that I last saw her ~~alive~~ on Oct 18. 3:00 PM 19
and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Intestinal infection
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No*
What test confirmed diagnosis?
(Signed) Ray McClellan, ~~M. D.~~
Oct. 18 30 (Address) County Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grove City Cem
Date of Burial 10-19-1930

20. Undertaker Modern Mortuary
Address Blackfoot

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72301

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 1
Primary Registration District No. 2194 Local Registrar's No. 152
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Doyle Willard Hansen 112
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE Years | Months 7 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls Ida
(State or country)

PARENTS
10. NAME OF FATHER Sidney Hansen
11. BIRTHPLACE OF FATHER (city or town) Bloomington Wash
(State or Country)
12. MAIDEN NAME OF MOTHER Maude Miller
13. BIRTHPLACE OF MOTHER (city or town) Taylor Ida
(State or County)

14. Informant Sidney Hansen
(Address)

15. Filed Oct 16, 1930 Mrs Helen E. Patrick
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 14, 1930
that I last saw him alive on Oct 13, 1930
and that death occurred, on the date stated above, at 8 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute indigestion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. J. Roberts, M. D.
Oct 14, 1930 (Address) Shelley Ida

19. Place of Burial, Cremation, or Removal Taylor, Idaho
Date of Burial Oct 16 1930

20. Undertaker Jack A. Wood
Address Idaho Falls, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72302

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 157

38

2. FULL NAME GEORGE WILLIAM FLEMING

(a) Residence. No. St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: MALE
4. COLOR OR RACE: NEGRO
5. Single, Married, Widowed, or Divorced (write the word): SINGLE

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Mar 12th 1904

7. AGE: 26 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Platsburg, Missouri

PARENTS

10. NAME OF FATHER: Dave Fleming Mo
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Harold Goldsworthy-Att'.
(Address) Blackfoot, Ida.

15. Filed Oct. 14, 1930 Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 12th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, 19, to Oct 12th 1930, 19
that I last saw him alive on Oct 12th 1930, 19
and that death occurred, on the date stated above, at 7:45 P m.
The CAUSE OF DEATH* was as follows:
Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Blood Wassermann
(Signed) Geo. Williams, M. D.
Oct 13th, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Asylum Cem. | Date of Burial: 1635

20. Undertaker: Adney Marion Clark | Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Rec'd NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72304

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007

Local Registrar's No. 149

(No. 610)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME. Leonard Lofquist

(a) Residence. No. 725 E Bridgeport St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 36 yrs | Months ✓ | Days ✓ | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) *General nature of industry*, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS

10. NAME OF FATHER Gus A Lofquist
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Gertrude James
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio.

14. Informant Gus A Lofquist
(Address) Blackfoot Idaho

15. Filed 10-9-, 1930 Mrs Helen E Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1930, to Oct 9, 1930
that I last saw h[illegible] alive on Oct 8, 1930
and that death occurred, on the date stated above, at 11 15 A.m.

The CAUSE OF DEATH* was as follows:
premature birth
at about 6 1/2 mo
lived 24 hrs
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J O Harrington M. D.
10-9-, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Firth Cemetery — Date of Burial: 10-9-30
20. Undertaker: Modern Mortuary — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72305

PLACE OF DEATH NOV 10 1930
County of Bingham
City of Shelley

Registration District No. 12
Primary Registration District No. 2.45
Local Registrar's No. 148
(No.) 105
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennatta Williams
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Geo. E. Williams
6. DATE OF BIRTH (month, day and year)
7. AGE 56 Years 1874 Months Mch. Days 22 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) West Jordan Utah
PARENTS
10. NAME OF FATHER Freeman Higley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Nancy Sharp
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah
14. Informant (Address) S. A. Williams
15. Filed Oct 10, 1930 Mrs Helen E. Patrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 8 (Day) 30 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1930, to Oct 8th, 1930
that I last saw her alive on Oct 7th, 1930
and that death occurred, on the date stated above, at 4:45 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Asthma
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 20 yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. W. Robertson, M. D.
Oct. 9th, 1930 (Address) Shelley Ida
19. Place of Burial, Cremation, or Removal Blackfoot Idaho Date of Burial Oct 10 1930
20. Undertaker Jack A. Wood Address Idaho Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72306

PLACE OF DEATH
County of Blaine
City of Carey

Registration District No. 57
Primary Registration District No. 2025
(No.) 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 34

2. FULL NAME Toresto A Josselyn wright.
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jennie Josselyn

6. DATE OF BIRTH (month, day and year): Nov 23-1855

7. AGE: Years 74 Months 10 Days 24 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fayette Maine

PARENTS
10. NAME OF FATHER: X
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: X True
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant: Jennie Josselyn
(Address) Carey Idaho

15. Filed 10-30, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-8, 1930, to 10-17, 1930
that I last saw him alive on 10-17 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of ✓
Was there an autopsy? no.
What test confirmed diagnosis? clinical
(Signed) Robert H. Wright, M. D.
10-30, 1931 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey, Idaho — Date of Burial: Oct 19 1930

20. Undertaker: Harris & Amos — Address: Hailey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72307

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

122

2. FULL NAME George R. Brooks

(a) Residence. No. ..... St. ..... Fox
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cassie Brooks

6. DATE OF BIRTH (month, day and year): July 21-1873

7. AGE: Years 57 | Months 2 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Wheatland Mo.

PARENTS

10. NAME OF FATHER: Columbus E. Brooks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Selma Bartche
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Hodys Brooks.
(Address): Hailey - Idaho

15. Filed 10-30, 1930 R. H. Wright - Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 16, 1930
that I last saw him alive on Oct 16, 1930
and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows: Gastric Hemorrhage from Gastric ulcer and Cirrhosis of Liver
(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Influenza
(duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death? L
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) E. W. [illegible], M. D.
10/27, 1930 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey Idaho | Date of Burial: Oct 19 1930

20. Undertaker: Harris & Amos | Address: Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72308

Local Registrar's No. 32

PLACE OF DEATH
County of Blaine
City of Bellevue

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Albert Baldwin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) 1872

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Thomas S Baldwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Ann Selman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Theodore Baldwin
(Address) Bellevue Ida

15. Filed 10-30, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... , 19..... to ..... , 19.....
that I last saw h..... alive on ..... 6 , 19.....
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
Fell dead -
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Robert H. Wright, M. D.
10/13, 1930 (Address) Co Coroner Hailey Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bellevue Ida.	Oct 17 1930
20. Undertaker	Address
Harris & Sons	Hailey Ida

RECEIVED NOV 22 1930
RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72309

PLACE OF DEATH
County of Blaine
City of

Registration District No. 57
Primary Registration District No. 2022
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 31

302-6

2. FULL NAME Benaiah Titcomb

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): X

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 70 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Prospector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Connecticut

PARENTS

10. NAME OF FATHER: X
11. BIRTHPLACE OF FATHER (city or town) (State or Country): X
12. MAIDEN NAME OF MOTHER: X
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): X

14. Informant: Geo. W. Campbell
(Address) Hailey

15. Filed 10-30, 1930 R. H. Wright
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about Oct 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19, to ✓, 19
that I last saw h alive on ✓, 19
and that death occurred, on the date stated above, at ✓ m.
The CAUSE OF DEATH* was as follows: Found dead - Evidently died of exposure - No inquest necessary -
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. ✓ mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Robert H. Wright, M.D.
10 - 8, 1930 (Address) Co. Coroner - Blaine Hailey, Ida - Co -

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Head of Mattingaly Creek	Oct 22 1930
20. Undertaker: Buried by Geo Campbell Sheriff	Address: Oct 22 1930

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 3 1930

STATE DEPARTMENT OF WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72310

PLACE OF DEATH

County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2922
Local Registrar's No. 30

(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11B

2. FULL NAME Mable Helen McCoy

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Arnold McCoy.

6. DATE OF BIRTH (month, day and year) Oct 12 1899

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	11	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Bellevue Ida.

PARENTS

10. NAME OF FATHER James A Benchain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colorado.
12. MAIDEN NAME OF MOTHER Lydia Zemmer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant Arnold McCoy.
(Address) Ketchum Ida.

15. Filed 10-30, 1930 P. H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Oct 1, 1930
that I last saw her alive on Oct 1, 1930
and that death occurred, on the date stated above, at 7.20 P. m.
The CAUSE OF DEATH* was as follows:
el influenza (Hemolytic type)
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) Menigitis and acute nephritis
(duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? Ketchum, Ida
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) E. W. Tot M. D.
Oct 2, 1930 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ketchum Idaho	Oct 4 1930
20. Undertaker	**Address**
Harris & Amor	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7231[illegible]

PLACE OF DEATH

County of Boise

City of Near Lowman

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

143

2. **FULL NAME** Harold Glade Fisher

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura A. Fisher

6. DATE OF BIRTH (month, day and year) February 23rd

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	8	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Grant Fisher

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Lithe Chamberlin

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant Grant Fisher
(Address)

15. Filed ....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no doctor, 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Accidental gunshot wound causing instant death, said wound being caused by Reuben Loftquist.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. A. Nelson M.D.

Nov. 5th, 1930 (Address) Idaho City, Ida.

19. Place of Burial, Cremation, or Removal Payette, Idaho — Date of Burial Oct. 19 193[illegible]

20. Undertaker I. H. Adair Peterson Furn. Co. — Address Payette, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72312

PLACE OF DEATH
County of BONNER
City of GRANITE

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 80

(No. 186)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME CLAYTON HAGADONE

(a) Residence. No. 332 St Clair Street St. SANDPOINT IDAHO.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 13, 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18		15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Loading Trucks at Gravel Pit
(c) Name of employer Arnett & Son; Contractors

9. BIRTHPLACE (city or town) Culbertson
(State or country) Montana

PARENTS

10. NAME OF FATHER George Hagadone

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Lula Stellpflue

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Wisconsin

14. Informant George Hagadone
(Address) 332 St Clair St. Sandpoint, Idaho

15. Filed Oct 31, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:
Accidental Traumatism by Landslide in Gravel Pit

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) L. D. Moon, Coroner M. D.
Oct. 30, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Oct 31 1930
20. Undertaker: MOON MORTUARY	Address: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72313

Local Registrar's No. 79

1012

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 74
Primary Registration District No. 2155
(No. Oden)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Karen Benson

(a) Residence. No. Oden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peder Benson

6. DATE OF BIRTH (month, day and year) Nov 14 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	11	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER unobtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Peter Benson
(Address) Oden

15. Filed Oct. 27, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ On Oct 26, 1930, to , 19
that I last saw her alive on Oct 26, 1930
and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar, Right
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. T. Stackhouse, M. D.
10/27, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	10/29 1930
20. Undertaker Tunnell Co.	Address Sandpoint

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72314

PLACE OF DEATH
County of Bonner
City of Colburn

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 78

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME William J. Wally.

(a) Residence. No. Colburn, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Jack Bartlett
(Address) Colburn, Idaho.

15. Filed Oct. 21, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 18, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h.... alive on ....., 19....
and that death occurred, on the date stated above, at about 7:30 A m.

The CAUSE OF DEATH* was as follows:

Suicide by Firearms

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) L. A. Moon Coroner
Oct. 18, 1930. (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery.	Oct. 21, 1930.

20. Undertaker Moon Mortuary Address Sandpoint Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72316

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 7e
Primary Registration District No. 2155
Local Registrar's No. 75
(No. 9 Milltown)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Nelson

(a) Residence. No. 9 Milltown St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 22 1882

7. AGE	Years	Months	Days	If LESS than 1 day,
	46	1	12	hrs. or min.

8. OCCUPATION OF DECEASED Teamster
(a) Trade, profession, or particular kind of work Mill Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Humbird Lbr Co
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Nels Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Sofia Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Hugo Nelson
(Address) Spokane Wn

15. Filed Oct 6, 1930. Geo Gillen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 4, 1930
that I last saw h~~im~~ alive on Oct. 3, 1930
and that death occurred, on the date stated above, at 2:15 A.m.
The CAUSE OF DEATH* was as follows:

Acute Myocarditis
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Ethylism
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Wm F. Tyler, M. D.
Oct. 5, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	10/6 1930
20. Undertaker	Address
Turnbull Co	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1930

STATE OF ID
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72317

PLACE OF DEATH
County of Bonner
City of Sandpoint, Ida

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 74
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Luella Jenkins
(a) Residence. No. 801 Cedar St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

B1

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W M. Jenkins

6. DATE OF BIRTH (month, day and year) Dec 25 1890

7. AGE Years 39 Months 9 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marshfield Wis.

PARENTS
10. NAME OF FATHER John Farrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Marilla Longeway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) France.

14. Informant W M. Jenkins
(Address) 801 Cedar St

15. Filed Oct. 5, 1930 Viola Alem Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ did not attend 19 to 19
that I last saw h..... alive on ....., 19
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows: Pulmonary T.B.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Floyd G. Wendle M. D.
Oct-4-1930 (Address) County Physician Sandpoint Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinciest Cemetery
Date of Burial Oct 5 1930

20. Undertaker L. G. Moon
Address Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72319

PLACE OF DEATH
County of Bonner
City of Elmira
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 72

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Sproule Lodge

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Elizabeth Lodge

6. DATE OF BIRTH (month, day and year) May 13, 1846

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	4	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cumberland County Nova Scotia

PARENTS

10. NAME OF FATHER Matthew Lodge

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia

12. MAIDEN NAME OF MOTHER Sprpule

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant James F. Lodge
(Address) Elmira, Idaho.

15. Filed Oct. 5, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 1, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 -, 1930, to Aug. 17, 1930 that I last saw h[illegible] alive on Aug. 17th, 1930. and that death occurred, on the date stated above, at 2:15 a. m.
The CAUSE OF DEATH* was as follows:

Pernicious Anaemia.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Blood Examination.

(Signed) C E Lee, M. D.
Oct. 2, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mc Arthur, Idaho.	Oct. 5, 1930
20. Undertaker	Address
Moon Mortuary	Sandpoint, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 7 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72320

PLACE OF DEATH

County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155.
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 71

2. FULL NAME Andrew Snell

(a) Residence. No. ..... St. Columbus, N. Dak
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital
(Address) Sandpoint Idaho

15. Filed Oct 3, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to Sept. 29, 1930
that I last saw him alive on Sept. 29, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Columbus, N. Dak
Did an operation precede death? No Date of
Was there an autopsy? No Laboratory
What test confirmed diagnosis? ~~Floyd G. Wendle~~
(Signed) Floyd G. Wendle, M. D.
Oct. 3, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Pinecrest Cemetery
Date of Burial Oct. 3, 1930

20. Undertaker Moon Mortuary
Address Sandpoint Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72321

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 197

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME R. W. Nagle
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: 74 Years | Months: 10 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10. NAME OF FATHER: Thomas Nagle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Norris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Harold Nagle
(Address): Parker Idaho
15. Filed Oct 1, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 9th 19..
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 5th, 1930, to Oct 9, 1930
that I last saw him alive on Oct 8, 1930
and that death occurred, on the date stated above, at 1:00 a.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Parker Idaho
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Des Moines Ia. | Date of Burial: 19
20. Undertaker: V. J. Keller | Address: Rexburg

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72322

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2130
(No. L. D. S. Hospital)
Local Registrar's No. 196
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Schafer

(a) Residence. No. ... St. Shelby Rt #3
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Phillip Schafer

6. DATE OF BIRTH (month, day and year) September 27, 1882

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Martin Stahr
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia
12. MAIDEN NAME OF MOTHER Dorothy Hiens
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Russia

14. Informant Phillip Schafer
(Address) Shelby, Idaho

15. Filed OCT 9, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-, 1930, to 10-8-, 1930
that I last saw her alive on 10-7-, 1930
and that death occurred, on the date stated above, at 3-30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Status Epilepticus
Probably Traumatic
in Origin
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Oedema of Lungs
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical + Physical
(Signed) Edwin Cutler, M. D.
10-8-, 1930 (Address) Shelley

19. Place of Burial, Cremation, or Removal: American Falls, Idaho — Date of Burial: Oct 10 1930
20. Undertaker: Jack A. Wood — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72323

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 191

119

2. FULL NAME Delores Alma Fairchild

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1929

7. AGE: Years 1 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Idaho

PARENTS

10. NAME OF FATHER Alma Fairchild

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Burley Idaho

12. MAIDEN NAME OF MOTHER Florence Valentine

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Topeka Kansas

14. Informant J. H. Valentine
(Address) Idaho Falls Ida

15. Filed Oct 7, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 3, 1930
that I last saw her alive on Oct 5, 1930
and that death occurred, on the date stated above, at 4.15 P m.
The CAUSE OF DEATH* was as follows:
Acute Ileo Colitis
(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? Clinical
What test confirmed diagnosis?
(Signed) [signature], M. D.
10/7/30, 19 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: Oct. 8 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

REC'D NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72324

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2170 Local Registrar's No. 15X
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Madesto Jimeny 1a

(a) Residence. No. ..... St. Nampa, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 24, 1908

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22	7	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Abran Jemeny

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Tabina Rendou

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mexico

14. Informant Agapito Gamino
(Address) Ucon, Ida.

15. Filed Oct 7, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 4, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930 to Oct 4, 1930
that I last saw h[illegible] alive on Oct 4, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) + Mesentery Thrombosis Hemorrhage internal

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Nampa
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy

(Signed) [signature] M. D.
10/16, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Ida.	Oct, 6 1930

20. Undertaker Jack A. Wood, Idaho Address Falls, Ida.

REC[illegible] NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72325

Local Registrar's No. 193

129

PLACE OF DEATH

County of Bonneville · Registration District No. 23

City of Idaho Falls · Primary Registration District No. 2170

(No. Ee-D-L Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Neil Anderson

(a) Residence. No. 325 Cliff St. St.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed or divorced HUSBAND of (or) WIFE of Mrs Minnie anderson

6. DATE OF BIRTH (month, day and year) Nov 26 1856

7. AGE	Years.	Months	Days	If LESS than 1 day,
	73	10	3.	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10. NAME OF FATHER Neil Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Marie.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs Minnie Anderson

(Address) Idaho Falls Ida.

15. Filed Oct 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1930, to Sept. 29, 1930

that I last saw him alive on Sept 29, 1930

and that death occurred, on the date stated above, at 10,32 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) unknown yrs. mos. ds.

18. Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Harry L. Willson, M. D.

10/4, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	10/2 1930

20. Undertaker W. F. McHan Address Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

RECEIVED NOV 15 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72326

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2-4-0

Local Registrar's No. 17

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Norrell

(a) Residence. No. Idaho Falls St. RT #3

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 1, 1930

7. AGE Years	Months	Days	If LESS than 1 day, 2 - 3 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls.

PARENTS

10. NAME OF FATHER E. H. Norrell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ammon, Ida.

12. MAIDEN NAME OF MOTHER Dorothy Elizabeth Lyons

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Springville, Ut.

14. Informant (Address) E. H. Norrell Idaho Falls RT #3

15. Filed Oct 3, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct. 1, 1930

that I last saw him alive on Oct 1, 1930

and that death occurred, on the date stated above, at 11:50 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Wilson M. D.

10/31, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Ammon Ida.	Oct. 3 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72329

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 189
(No. L. O. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Phil Anderson Lott
(a) Residence. No. ..... St. Ucon, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 1, 1926

7. AGE Years 4 Months 4 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ucon, Idaho

PARENTS
10. NAME OF FATHER Candalonzo Lott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Beaver, Utah
12. MAIDEN NAME OF MOTHER Agnes Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clawson, Utah

14. Informant (Address) C. A. Lott Ucon, Idaho

15. Filed Oct 2, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Sept 30, 1930
that I last saw him alive on Sept 30, 1930
and that death occurred, on the date stated above, at 9:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Ucon
Did an operation precede death? no Date of .....
Was there an autopsy? ~~yes~~
What test confirmed diagnosis? clinical
(Signed) [signature], M. D.
Oct 2, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Ucon, Idaho Date of Burial Oct 2 1930

20. Undertaker Jack A. Ward Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72330

NOV 1 1930

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2147
(No. L.O.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1 8 8

H-4

2. FULL NAME Iva Belle Terry
(a) Residence. No. ..... St. Idaho Falls Rt #3
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 1, 1912

7. AGE Years 17 Months 9 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work General House Work
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Ucon, Idaho
(State or country)

PARENTS
10. NAME OF FATHER Ray Terry
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Ada Cutler
13. BIRTHPLACE OF MOTHER (city or town) Lewisville
(State or County)

14. Informant Ray Terry
(Address) Idaho Falls, Idaho

15. Filed Sept. 29, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 26, 1930
that I last saw her alive on Sept 26, 1930
and that death occurred, on the date stated above, at 10 o'clock m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute streptococcic Dermatitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical and Exp. H. Ray Hatch, M. D.
(Signed) Sept 29, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Ucon, Idaho
Date of Burial Sept 29 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72331

REC'D NOV 15 1930

PLACE OF DEATH

County of Bonneville Registration District No. 23
City of Idaho Falls Primary Registration District No. 2-1-4-D
Local Registrar's No. 2 7

(No.) 49(b)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William W. Dawson.

(a) Residence. No. 105 E. 14 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Jennie Dawson

6. DATE OF BIRTH (month, day and year) Aug 31 1846.

7. AGE	Years	Months	Days	If LESS than 1 day,
	84	1	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Conductor
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fredricka Delaware

PARENTS

10. NAME OF FATHER Asa. Dawson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Marcan Welton.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs Jennie Dawson
(Address) Idaho Falls Ida

15. Filed Oct 18, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 17, 1930, that I last saw h alive on Oct 16, 1930 and that death occurred, on the date stated above, at 5 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
3
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No.
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	10/19 1930
20. Undertaker	Address
W. F. McHan.	Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72332

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170

Local Registrar's No. 203

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Sannosuke Yamagata

(a) Residence. No. Rexburg St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Japanese	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hachi Yamagata

6. DATE OF BIRTH (month, day and year) Oct. 26, 1875

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	II	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) A tenant on John Lee's

(c) Name of employer Farm

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10. NAME OF FATHER Sogero Yamagata

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan

12. MAIDEN NAME OF MOTHER Hachi

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant T Joe
(Address) Rexburg Idaho

15. Filed Oct 14, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to Oct 14, 1930
that I last saw him alive on Oct 15 1930
and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

(a) Pyloric stenosis of stomach

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of Oct 13-193
Was there an autopsy? Yes
What test confirmed diagnosis? Laboratory & Surgical findings

(Signed) [illegible] M. D.
10-17, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial
Rexburg Cemetery 10/19 1930

20. Undertaker — Address
Russell R. Flamm Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72333

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 & 20 Local Registrar's No. 202
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grove Hanger
(a) Residence. No. 10th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth E. Hanger

6. DATE OF BIRTH (month, day and year)

7. AGE Years 73 Months 8 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS
10. NAME OF FATHER James Hanger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Hannah Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Mrs. H. C. Humphrey Giltner, Nebr.

15. Filed Oct 17, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9:15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Indefinite
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Acute Bronchitis
(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John O. Miller M. D.
Oct 16, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida. Date of Burial Oct. 17 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72334

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2,1-0
Local Registrar's No. 201
(No.) 770
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Floyd Joseph Rowe
(a) Residence. No. St. Rigby, Rt. #3, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of May Rowe
6. DATE OF BIRTH (month, day and year) Feb. 23. 1899
7. AGE Years 31 Months 7 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Thayne Wyo.

PARENTS
10. NAME OF FATHER J. M. Rowe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mendon Utah
12. MAIDEN NAME OF MOTHER Josephine Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) Le Von Rowe 555 Chamberlain, Idaho Falls
15. Filed Oct 17, 1930 [signature] M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 16 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to Oct 16, 1930
that I last saw him alive on Oct 16, 1930
and that death occurred, on the date stated above, at 1 A. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Endocarditis with Mitral regurgitation
Unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac decompensation
(duration) yrs. 6 mos. ds.
18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Laboratory
(Signed) W. R. Abbott M. D.
Oct 18, 1930 (Address) Ririe Idaho.

19. Place of Burial, Cremation, or Removal Rigby, Ida. Date of Burial Oct. 18 1930
20. Undertaker Jack A. Wood Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72335

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21V-0 Local Registrar's No. 200
100a
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grant Hollist
(a) Residence. No. Idaho Falls L.D.S. Hospital St. St. Anthony, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 26, 1928

7. AGE Years 2 Months Days 1' If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilford, Idaho

PARENTS
10. NAME OF FATHER William D Hollist
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Farmington Utah
12. MAIDEN NAME OF MOTHER Sarah E. Orme
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tooele Utah

14. Informant (Address) William D. Hollist

15. Filed Oct. 13, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 9, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 9, 1930
that I last saw him alive on Oct 9, 1930
and that death occurred, on the date stated above, at 5:06 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchonial Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) 0
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) H Ray Hatch M. D.
Oct 10, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal St. Anthony Idaho
Date of Burial Oct. 1930

20. Undertaker
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72336

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 199
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Mary R. Shaw
(a) Residence. No. Avalon Apts St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. Shaw

6. DATE OF BIRTH (month, day and year) June 14, 1859

7. AGE Years 71 Months 8 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Jackson Coil
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Sarah Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Maine

14. Informant (Address) Bernice S. Blagg Avalon Apt. Idaho Falls

15. Filed Oct 12, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1930, to Oct 9th, 1930
that I last saw her alive on Oct 6th, 1930
and that death occurred, on the date stated above, at 11 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical exam
(Signed) F. A. Anderson, M. D.
Oct 9th, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal Sioux City, Iowa Date of Burial Oct 14 1930

20. Undertaker Jack A. Wood Address Idaho Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72337

REGISTERED NOV 15 1930

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2140
Local Registrar's No. 198
(No. 113)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Clarence Eugene Hunter
(a) Residence. No. (Usual place of abode.) St. Idaho Falls Rt #2
(If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17, 1929

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colman Idaho.

PARENTS

10. NAME OF FATHER C. H. Hunter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Edna Louise Robinson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Colman, Idaho.

14. Informant (Address) C. H. Hunter Idaho Falls Rt. #2

15. Filed Oct 11, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on Oct. 9th, 1930
and that death occurred, on the date stated above, at 2:30 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diarrhea & Enteritis
under 2 yrs.
Malnutrition
(duration) ....yrs. ....mos. 30 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) Dr. [illegible]
Oct 11, 1930 (Address) Idaho Falls Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grant, Idaho	Oct. 11 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 17 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72338

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with unfading ink—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

1 PLACE OF DEATH
County Boundary State Idaho Registered No.
Township or Village or
City Mission near Bonners Ferry, Ida. No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alban Chiqui

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mission near
(State or country) Bonners Ferry, Idaho

PARENTS

10 NAME OF FATHER Eneas Pierre Chiqui

11 BIRTHPLACE OF FATHER (city or town) Mission near
(State or country) Bonners Ferry, Idaho

12 MAIDEN NAME OF MOTHER Catherine Temo

13 BIRTHPLACE OF MOTHER (city or town) Mission near
(State or country) Bonners Ferry, Idaho

14 Informant Phena Anderson
(Address) Bonners Ferry, Idaho.

15 Filed ----------, 19 ----------
REGISTRAR

11—3184

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1930, to Aug. 30 1930,
that I last saw him alive on Aug. 20 1930,
and that death occurred, on the date stated above, at ---------- m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical examinatio

(Signed) R. M. Bowell, M. D.
9/1530, 19 (Address) Bonners Ferry, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72339

PLACE OF DEATH

County of Canyon

City of Parma.

Registration District No. 3

Primary Registration District No. 1007

Local Registrar's No. 7

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Louis Samuel Applegate.

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White	

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	8	— hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) Parma Ida.
(State or country)

PARENTS

10. NAME OF FATHER Samuel Applegate

11. BIRTHPLACE OF FATHER (city or town) Shell Knob - Mo.
(State or Country)

12. MAIDEN NAME OF MOTHER Effie Ethel Meadows.

13. BIRTHPLACE OF MOTHER (city or town) Maine - Me.
(State or Country)

14. Informant L. Ann Applegate
(Address)

15. Filed Nov 10, 1930 Lulu Incaldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Oct 30, 1930
that I last saw him alive on Oct 30, 1930
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) O. M. Mitchell, M. D.

10/31, 1930 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma	10-31 1930

20. Undertaker	Address
C. V. Peckham	Caldwell Idaho

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72340

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 16

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kenneth Arthur Douglas. 124

(a) Residence. No. Parma # 1 St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 11-1914

7. AGE: Years 16 | Months 2 | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Boise Idaho

PARENTS

10. NAME OF FATHER: Guy A. Douglas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska
12. MAIDEN NAME OF MOTHER: Rose D. Bacon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Boise Idaho

14. Informant: Guy A. Douglas
(Address) Parma Idaho

15. Filed 11-7, 1930 Ruby Waldron Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 11, 1930, that I last saw h~~im~~ alive on Oct 11, 1930, and that death occurred, on the date stated above, at 9-30 a. m.

The CAUSE OF DEATH* was as follows:
Flu with acute Nephritis,
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? Parma Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Julian, M. D.
10/13, 1930 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

K.P.M.

19. Place of Burial, Cremation, or Removal: Roswell Cem | Date of Burial: 10/13, 1930

20. Undertaker: C. V. Peckham | Address: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72341

PLACE OF DEATH
County of Canyon
City of Parma
Registration District No. 9
Primary Registration District No. 1007
Local Registrar's No. 15
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriett Minerva Simon. 74a

(a) Residence. No. Parma City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 6 -

7. AGE: Years 87 | Months 4 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mahoning Co Ohio

PARENTS
10. NAME OF FATHER Jacob Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Catherine Crouse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant M. O. Simon
(Address) Parma Ida.

15. Filed 10-14, 1930 Lucy Waldo Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/8/30, 19..., to 10/11/30, 19...
that I last saw her alive on 10/10/30, 19...
and that death occurred, on the date stated above, at 7-30 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E. E. Jensen M. D.
10/16/30, 19... (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Cem.	10/14 1930
20. Undertaker C. V. Beckham	Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72342

PLACE OF DEATH NOV 15 1930

County of Canyon
City of Parma
Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 14
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Harling Smith Stockton
(a) Residence. No. Parma #1 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May-6-1846
7. AGE Years 84 Months 5 Days 3 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) McNeim Co Tennessee.

PARENTS
10. NAME OF FATHER H S Stockton
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Martha Oakes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W F Stockton
(Address) Parma Ida
15. Filed Oct 9, 1930 Lulu Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct - 9 - 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 4/10, 1930, to Oct 9, 1930
that I last saw him alive on Oct 8, 1930
and that death occurred, on the date stated above, at 4-30 a m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 8 yrs. mos. ds.
CONTRIBUTORY (Secondary) Artero-Schlorosis
(duration) 5 yrs. mos. ds.
18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urine examination Blood Pressure
(Signed) W M Mitchell, M. D.
10/11, 1930 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Tucker Cem
Date of Burial: 10-11 1930
20. Undertaker: C. V. Peckham
Address: Caldwell Ida

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72343

PLACE OF DEATH

County of Canyon
City of Parma
Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 19

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Calista Joshua Seiber. 90

(a) Residence. No. Parma Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Seiber

6. DATE OF BIRTH (month, day and year) Aug-9-1886

7. AGE	Years	Months	Days	If LESS than 1 day,
	44	1	28	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranching
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dougloula Co. Wisconsin

PARENTS

10. NAME OF FATHER Mathieu Seiber
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rome Co. Tennessee
12. MAIDEN NAME OF MOTHER Mary Edmon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jackson Co. Illinois

14. Informant Geo H Brown
(Address) Parma Ida

15. Filed Oct 9, 1930 Lulu Saldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) — 7 (Day) — 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 25 1930, to Oct. 7, 1930
that I last saw him alive on Oct. 6, 1930
and that death occurred, on the date stated above, at 3-30a m.
The CAUSE OF DEATH* was as follows:
Rheumatic Heart Disease

(duration) 2 yrs. 10 mos. — ds.
CONTRIBUTORY (Secondary) Upper Respiratory Infection
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) E C Jensen, M. D.
10/8/30, 19 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Greenleaf Cem.	10-9 1930
20. Undertaker G. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO

RECEIVED NOV 13 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72344

PLACE OF DEATH

County of Canyon

City of Notus

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005 Local Registrar's No. 122

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Judson Mongrief Jaggart

(a) Residence. No. Wilder St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 27-1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	4	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER Mather Jaggart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.

12. MAIDEN NAME OF MOTHER Sarah Eberhart

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant D. O. Jaggart (Address) Notus Ida

15. Filed 10-13-, 1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 15, 1930, to Oct 8, 1930, that I last saw him alive on Oct 7, 1930 and that death occurred, on the date stated above, at 4:40 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) Robert E Talbot, M. D.

Oct 10, 1930 (Address) Wilder

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder	10-9-1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72345

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 123
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

113

2. FULL NAME Vernon Roy Alsup

(a) Residence. No. Kuston Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 10" 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Idaho.

PARENTS

10. NAME OF FATHER H. H. Alsup.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash.
12. MAIDEN NAME OF MOTHER Viola Cole.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Guthrie Oklahoma

14. Informant H. H. Alsup
(Address) Kuston Idaho R 1

15. Filed 10-13-, 1930. John S. Meyer - Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 10" (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-3, 1930, to Oct-10, 1930, that I last saw him alive on Oct 10, 1930 and that death occurred, on the date stated above, at 9. P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Thrombosis - Coronary

(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? x
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) S. R. Dudley, M. D.
Oct 11, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-12 1930
20. Undertaker C. W. Peckham	Address Caldwell Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED NOV 13 1930

DO NOT WRITE IN THIS SPACE

State File No. 72346

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 124

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Alice Grimes. 47

(a) Residence. No. So 10th St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of A J Grimes

6. DATE OF BIRTH (month, day and year) April 8 - 1888

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42	6	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kirksville
(State or country) Missouri

PARENTS

10. NAME OF FATHER J J Morrow

11. BIRTHPLACE OF FATHER (city or town) Missouri
(State or Country)

12. MAIDEN NAME OF MOTHER Mary Saltzman

13. BIRTHPLACE OF MOTHER (city or town) Summerset, Co.
(State or County) Penn

14. Informant G D Grimes
(Address) So 10th Caldwell Ida.

15. Filed 10-15-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 12 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 28, to Oct 12-, 1930
that I last saw her alive on Oct. 11-, 1930
and that death occurred, on the date stated above, at 9:15a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH was as follows:

Metastatic Carcinoma
Primary in left breast, later
involved right femur and
ilium

(duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? yes Date of Feb. 1928
Was there an autopsy? No
What test confirmed diagnosis? Physical & X rays

(Signed) C M Haley, M. D.
10-13-, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Simpson Hill	10-15 1930
20. Undertaker C J Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72347

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 125
(No.) 41
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eunice Palmer

(a) Residence. No. no Caldwell Rt 2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 21-1907

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho.

PARENTS

10. NAME OF FATHER N. W. Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Effie Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) N W Palmer Caldwell Ida Rt 2

15. Filed 10-15- 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Octo 10th, 1930, to Octo 12th, 1930, that I last saw h.. alive on Octo 12th, 1930 and that death occurred, on the date stated above, at 8:50 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Septicemia
originating from a small pimple with
glands on side of face - spreading
to glands of neck & chest - became gen
CONTRIBUTORY (Secondary) involving heart
(duration) 0 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) John Beach M. D.
Octo 14th 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-15 1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72348

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 126

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

124

2. FULL NAME H Lillian Hazel Riggs

(a) Residence. No. Parma, Idaho R#2 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Everett Riggs

6. DATE OF BIRTH (month, day and year) Jan 12th 1907

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
23	9	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Roswell
(State or country) Idaho.

PARENTS

10. NAME OF FATHER W M Fretwell
11. BIRTHPLACE OF FATHER (city or town) Clark Co.
(State or Country) Missouri
12. MAIDEN NAME OF MOTHER Fannie Ramsey
13. BIRTHPLACE OF MOTHER (city or town) Louis Co.
(State or County) Missouri

14. Informant Everett Riggs
(Address) Parma R#2

15. Filed 10-18-, 1930. John L. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 8, 1930, to Oct 13, 1930
that I last saw her alive on Oct 12, 1930
and that death occurred, on the date stated above, at 6 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Bright's
Acute Interstitial Nephritis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary) .....
.....(duration) .....yrs. 3 mos. 13 ds.

18. Where was disease contracted if not at place of death? Parma Idaho
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Robert E Talbot M. D.
Oct 13, 1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell	10-16 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72349

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 127
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Roy Glen Mathews

(a) Residence. No. Wilder St. Idaho.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 23 - 30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3 wks	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wilder, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER L. J. Mathews
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Grace Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas

14. Informant L. J. Mathews
(Address) Wilder, Idaho

15. Filed 10-16-, 1930. John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 14, 1930
that I last saw h.im. alive on Oct 14, 1930
and that death occurred, on the date stated above, at 12 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. C. Wolfe M. D.
Oct 16, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilder, Ida	10-15-1930
20. Undertaker C. V. Peckham	Address Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72350

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Canyon
City of Caldwell.

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 128
(No. 114)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Delbert Daniel Davis.
(a) Residence. No. Huston St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced. (write the word.)
male	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 10-28

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Caldwell
(State or country) Idaho

PARENTS

10. NAME OF FATHER George C. Davis
11. BIRTHPLACE OF FATHER (city or town) Garfield Co
(State or Country) Wash.
12. MAIDEN NAME OF MOTHER Rose M Hall.
13. BIRTHPLACE OF MOTHER (city or town) Lafayette Co.
(State or County) Wash.

14. Informant George C Davis
(Address) Huston, Idaho R#1

15. Filed 10-18-, 1930. John S. Meyers
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 15 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 13, 1930, to October 15, 1930
that I last saw h alive on October 15, 1930
and that death occurred, on the date stated above, at 9 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. R. Whittenberger M. D.
10-17, 1930 (Address) Caldwell Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	10-17 1930
20. Undertaker C. V. Peckham	Address Caldwell Id.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72351

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 129
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Peter J. Johnson

(a) Residence. No. Odd Fellows Home St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 20 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Razard Torpe Kronoberg Sweden

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown Sweden

14. Informant V.H. Mrs. Price
(Address) Caldwell Idaho

15. Filed 10-20-, 1930 John S. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-17, 1930, to Oct-19, 1930
that I last saw him alive on Oct-17, 1930
and that death occurred, on the date stated above, at 2.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Art Sclerosis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) S. S. Mueller, M. D.
Oct 20, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot, Idaho	19
20. Undertaker: Paul L. Case	Address: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

July 31

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72352

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 130
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME William Album Douglas
(a) Residence. No. So 10" Caldwell St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 9-1930

7. AGE: 81 Years | Months: 3 | Days: 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10. NAME OF FATHER: Geo. Douglas
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Christina Beggs
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ohio.

14. Informant (Address): E. G. Douglass So 10" Caldwell Ida

15. Filed 10-24-1930. John S. Meyer. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31, 1930 to Oct. 20, 1930
that I last saw him alive on Oct. 19, 1930
and that death occurred, on the date stated above, at 2:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Uremia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) C. M. Haley, M. D.
10-20-1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill | Date of Burial: 10-22 1930

20. Undertaker: C. V. Peckham | Address: Caldwell Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72353

RECEIVED NOV 13 1930

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 131
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Earl Wilson Perkel

(a) Residence. No. Route 1 Wilder Ida St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 7-10-19

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	3	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilder Idaho

PARENTS

10. NAME OF FATHER George W.Perkel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Middleton Idaho
12. MAIDEN NAME OF MOTHER Anna Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Provo Utah

14. Informant George W.Perkel
(Address) Wilder Ida

15. Filed 10-26, 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2, 1927, to Oct 21, 1930
that I last saw him alive on Oct 21, 1930
and that death occurred, on the date stated above, at 8 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease
Themselves
Chronic Nephritis
(duration) 3 yrs. 8 mos. 19 ds.

CONTRIBUTORY (Secondary) Ascites -
(duration) yrs. 6 mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no —
What test confirmed diagnosis?
(Signed) Robert E Talbot, M. D.
Oct 27, 1930 (Address) Wilder

19. Place of Burial, Cremation, or Removal: Canyon Hill, Caldwell — Date of Burial: Idan 10-26-30

20. Undertaker: Paul L.Case — Address: Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72354

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 132
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

12-

2. **FULL NAME** Hattie Elizabeth Davis

(a) Residence. No. 422 Blaine St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of C. L. Davis

6. DATE OF BIRTH (month, day and year) Nov 8 1876

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	11	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Robert S. Rude

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Edenburg Scotland

12. MAIDEN NAME OF MOTHER Elizabeth Seater

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois?

14. Informant (Address) C. L. Davis 422 Blaine Caldwell Ida

15. Filed 10-27-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10, 1930, to Oct 25, 1930
that I last saw h.er alive on Oct 25, 1930
and that death occurred, on the date stated above, at 11 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Sarcoma of Pancreas
causing Apoplexie
Anemia
(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) W. D. Jones, M. D.
Oct 27, 1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-28 1930

20. Undertaker	Address
C. V. Peckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

NOV 1 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72355

PLACE OF DEATH

County of Canyon
City of Wilder, Idaho

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 133
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Fenton Rippey

(a) Residence. No. Wilder, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 8, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
- - -	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wilder, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Roscoe Rippey

11. BIRTHPLACE OF FATHER (city or town) Oklahoma
(State or Country)

12. MAIDEN NAME OF MOTHER Autom Paxton

13. BIRTHPLACE OF MOTHER (city or town) Oklahoma
(State or County)

14. Informant Mrs. Roscoe Rippey
(Address) Wilder Idaho

15. Filed 10-28-, 1930. John L. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 - 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 24, 1930, to Oct 26, 1930
that I last saw him alive on Oct 26, 1930
and that death occurred, on the date stated above, at 11 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Marasmus
Unproductive pleadings and [illegible]

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Robert E. Lee Ward, M. D.
Oct x, 1930 (Address) Wilder

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Idaho	10-27-30 19

20. Undertaker	Address
Paul L. Case	Caldwell Idaho

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72356

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 134
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Mattison H Miller
(a) Residence. No. Caldwell, Ida. R#1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22 1841

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
89	3	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Brick mason
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) Artie Castle R#1 Caldwell, Idaho

15. Filed 11-4-, 1930- John S. Meyer- Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 10, 1914, to Oct 27, 1930
that I last saw him alive on Oct 27, 1930
and that death occurred, on the date stated above, at 7:50 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis of the aged —

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) T. D. Farrar M. D.
Oct 29, 1930 (Address) Caldwell

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	10-30 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72357

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 135
(No. Memorial Park Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Francis Lafayette Suiter

(a) Residence. No. Roswell Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 4 1891

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	2	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington State

PARENTS

10. NAME OF FATHER Marion F Suiter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Lydia Ford
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant Mrs F.L.Suiter
(Address) Roswell Idaho

15. Filed 11-6-, 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 5, 1930
that I last saw him alive on Nov 5, 1930
and that death occurred, on the date stated above, at 11 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) W.W. Montgomery M. D.
Nov 5, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Roswell Cemetery	11-8- 1930
20. Undertaker	Address
Paul L. Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED NOV 1 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72358

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 136
(No. Memorial Park Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Ira Hamilton

(a) Residence. No. So. 10" st St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 3 1855

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Wm Hamilton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky

12. MAIDEN NAME OF MOTHER Hannah Baldridge

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant (Address) Mr Richard Beatty Caldwell Idaho

15. Filed 11-6-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1924, to Nov 5, 1930
that I last saw h[illegible] alive on Nov 5, 1930
and that death occurred, on the date stated above, at 8 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility
Natural sclerosis
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Amputation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov 1/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. Montgomery M. D.
Nov 6, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Nampa Idaho Kohlerlawn cemetery — Date of Burial: 11-7-30 19

20. Undertaker: Paul L. Case — Address: Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72359

PLACE OF DEATH

County of Canyon
City of Caldwell

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 137
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward D. Barney
(a) Residence. No. Middleton Ida. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

15-5

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 1 - 1872

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	1	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Aneta
(State or country) Iowa

PARENTS

10. NAME OF FATHER Andrew Barney
11. BIRTHPLACE OF FATHER (city or town) Gilford
(State or Country) Vermont
12. MAIDEN NAME OF MOTHER Menera Deitrick
13. BIRTHPLACE OF MOTHER (city or town) Sunberry
(State or County) Penn

14. Informant (Address) Sadie M. Barney Middleton, Ida.

15. Filed 11-11- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1930, to Nov. 5, 1930
that I last saw him alive on Nov 5, 1930
and that death occurred, on the date stated above, at 9 30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Sarcoma of Longbones
Legs with metastasis
in Lungs
(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Injury to hip
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Xrays
(Signed) M. Kaley, M. D.
11-6- 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Canyon Hill
Date of Burial: Nov 7 1930

20. Undertaker: C. V. Peckham
Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72360

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 138
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Katherine Converse 90

(a) Residence. No. 1002 Belmont St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 19-1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	9	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewisberry
(State or country) Penn.

PARENTS

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or County)

14. Informant W C Lester
(Address) W 1002 Belmont.

15. Filed 11-11-, 1930. John L. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Nov 4, 1930, that I last saw her alive on Nov 1, 1930, and that death occurred, on the date stated above, at 5 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mitral Stenosis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W C Lester M. D.
, 19 (Address) 2:30

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: Nov 6 1930

20. Undertaker: C V Peckham — Address: Caldwell Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72361

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 139
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. **FULL NAME** Callistus Wm Cooper

(a) Residence. No. 910 Main St. Caldwell St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Dora Cooper

6. DATE OF BIRTH (month, day and year) Oct 14 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	0	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Long Grove Iowa

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Elder

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) Mrs W. B. Montgomery 910 main St. Caldwell Ida

15. Filed 11-6-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 1 (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 1, 1930, that I last saw him alive on Nov 1 dead 1930, and that death occurred, on the date stated above, at 9 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hyp & Art. Sclerosis

(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Y
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinic Findings

(Signed) Bob Dudley, M. D.
Nov 3, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Nov 3 1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC'D NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72362

PLACE OF DEATH

County of Canyon.

City of Nampa.

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hosp't.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 116

74A

2. FULL NAME Frances Marion Wildman.

(a) Residence. No. 1012-12Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 1, 1862.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	1	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) (retired)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER F.M. Wildman.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill/

12. MAIDEN NAME OF MOTHER Möller.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Glenn Waldman
(Address) Nampa Idaho

15. Filed Oct 2, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Sep 29, 1930
that I last saw him alive on Sep 29, 1930
and that death occurred, on the date stated above, at 5-20 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
with Left side paraplegia

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) H.P. Rosa, M. D.
Oct 1, 1930 (Address) Nampa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn.	10/2 1930
20. Undertaker F.K/ Robinson	Address Nampa.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72363

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 117

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Robert Sparks

(a) Residence. No. (Rural) St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 29, 1930

7. AGE Years Months Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Nampa (State or country) Canyon

PARENTS

10. NAME OF FATHER Mitchel Sparks

11. BIRTHPLACE OF FATHER (city or town) Dingle (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Nellie Lamm

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Colorado

14. Informant Mr Mitchel Sparks

(Address) Milba Ida R. #1

15. Filed 10/3, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 1, 1930

that I last saw him alive on Oct 1, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

reopening of foramen ovale

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral haemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical-spinal puncture

(Signed) H F Neal, M. D.

10-2, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cem

Date of Burial 10-3 1930

20. Undertaker F. K. Robinson

Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72364

RECEIVED NOV 10 1930

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 706
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 118

2. **FULL NAME** Melissa E. Sample

(a) Residence. No. 6 mi. east Power Line Rd. St.
(Usual place of abode.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 23rd 1871

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	9	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) McMinnville, Oregon

PARENTS

10. NAME OF FATHER John B. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Lucy F. Pinkerton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) Mr. Everett Sample Klamath Falls, Oregon

15. Filed 10-7, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Oct 3, 1930, that I last saw her alive on Oct 3, 1930, and that death occurred, on the date stated above, at 3:15 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Horace B Belknap M D
10/4, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal Morris Hill-Boise, Ida. Date of Burial 10-7 193[illegible]

20. Undertaker Mrs. Nina M. Falke, Nampa Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72365

PLACE OF DEATH
County of Kenyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No.) 131
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 119

2. FULL NAME John Wallace Groesbeck
(a) Residence No. Pleasant addition St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Groesbeck

6. DATE OF BIRTH (month, day and year) Feb. 7, 1857

7. AGE Years 73 Months 8 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Steve Groebeck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Pat Groebeck
(Address) Pleasant Addition

15. Filed 10-8, 1930 Nampa Ida. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 2, 1930, to Oct 5, 1930
that I last saw him alive on Oct 5, 1930
and that death occurred, on the date stated above, at 5-30 a.m.
The CAUSE OF DEATH* was as follows:
Uremia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Intestinal Flu
(duration) yrs. 1 mos. 3 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J C Bellknap, M. D.
Oct 8, 1930 (Address) J C Bellknap

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cemetery
Date of Burial Oct 7, 1930

20. Undertaker F K Robinson
Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72366

Local Registrar's No. 120

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. 501)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Catheren Gillesby.

(a) Residence. No. 512-9 Ave. S. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apl. 11, 1848

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	6		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meford Canada.

PARENTS

10. NAME OF FATHER Maraleran

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Mrs. Ray Gillesby

(Address) 512-9 Ave. S.

15. Filed 10/8, 1930 Leetha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1930, to Oct 5, 1930

that I last saw her alive on Oct 5, 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of hip

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. H. Ross, M. D.

Oct 8, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	10/8 30 19

20. Undertaker F.K. Robinson.

Address Nampa IDA.

Ross

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72367

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 21
(No. 1 mi. so. 12th Ave Rd)
(If death occurred in a hospital or institution, give its name instead of street and number.)

4H

2. **FULL NAME** Charles Vail

(a) Residence. No. 1 mi. so. 12th Ave. Rd. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 28th 1920

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	4	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER Arthur E. Vail.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Elnora Albright
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas

14. Informant Mrs Arthur Vail.
(Address) Nampa Idaho

15. Filed 10-12, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to Oct 8, 1930, that I last saw him alive on September 30, 1930, and that death occurred, on the date stated above, at 2:15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Brain tumor

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W. C. Wolfe M. D., M. D.
Oct. 11, 1930 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa. Date of Burial: 10-12 1930
20. Undertaker: Wm D. Talley Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72368

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

161 B

2. FULL NAME Elva Mae Bullen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12-30

7. AGE Years | Months | Days | If LESS than 1 day, 14-20 hrs. or min.

8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nampa Ida

PARENTS

10. NAME OF FATHER L. C. Bullen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Marie Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn

14. Informant L. C. Bullen
(Address) Nampa, Ida

15. Filed 10-13, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1930, to Oct 13, 1930
that I last saw h..... alive on Oct 13, 1930
and that death occurred, on the date stated above, at 4 AM m.
The CAUSE OF DEATH* was as follows:
Cerebral Birth Injuries
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel A Swayne M. D.
Oct. 13, 1930 (Address) Nampa, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Catholic Cem
Date of Burial: 10-17 1930

20. Undertaker: F. K. Robinson
Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72369

PLACE OF DEATH

County of Canyon
near City of Bowmont

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 2006
(No. 4 mi so. east Bowmont.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 123

149

2. FULL NAME Lewis N. Fenne.

(a) Residence. No. 4 mi. so. east Bowmont St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 21st 1861

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	8	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: self.

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Chicago. Illinois

14. Informant (Address): Mrs. L. N. Fenne. Nampa, Idaho

15. Filed 10-16, 1930 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 14th, 1930
that I last saw him alive on Oct 13th, 1930
and that death occurred, on the date stated above, at 10:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
He was attacked by a vicious bull - Knocked down and face and body tramped on - Chest injury was fatal
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) F J Coleman, M. D.
Oct 15, 1930 (Address) Kuna Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn - Nampa. Date of Burial: 10-17 1930

20. Undertaker: Mrs. Nina M. Talley Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72370

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 7
Primary Registration District No. 2006 Local Registrar's No. 124
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel B Sexton
(a) Residence. No. Caldwell Ida R#1 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

880

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of P. W. Sexton

6. DATE OF BIRTH (month, day and year) Oct 28" 1889

7. AGE Years 41 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Summersville
(State or country) Oregon

PARENTS
10. NAME OF FATHER F. J. Ott
11. BIRTHPLACE OF FATHER (city or town) Ind
(State or Country)
12. MAIDEN NAME OF MOTHER Rebecca Ann Hudsel
13. BIRTHPLACE OF MOTHER (city or town) Tenn
(State or County)

14. Informant (Address) P. W. Sexton R#1 Caldwell Ida

15. Filed 10-31, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 - 1930, to Oct. 28, 1930
that I last saw her alive on Oct. 8 - 1930
and that death occurred, on the date stated above, at 5 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
Endocarditis.
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel A Swayne M. D.
Oct 31 - 1930 (Address) Nampa, Id

19. Place of Burial, Cremation, or Removal
Date of Burial 10-29 1930

20. Undertaker C. V. Peckham
Address Caldwell, Id.

RECEIVED OCT 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72371

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Heber Field

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Field

6. DATE OF BIRTH (month, day and year) Jan. 1 1865

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Slaterville
(State or country) Utah.

PARENTS

10. NAME OF FATHER William Field

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Ill

12. MAIDEN NAME OF MOTHER Charlotte Bult

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) England

14. Informant (Address) Robert W Field Idaho Falls

15. Filed 10-15-, 1930 F. A. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 1 1930, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Sept 1st, 1930 that I last saw him alive on Sept 1st, 1930 and that death occurred, on the date stated above, at 4.20A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Valvular Heart trouble

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinic

(Signed) F. A. Carter, M. D.
Sept 2nd, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: Sept. 3 1930

20. Undertaker: D. C. Johnson — Address: Burley

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72372

PLACE OF DEATH

County of Cassia
City of Yale

CERTIFICATE OF DEATH

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** R. H. Knapp

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 1865

7. AGE: Years 63 | Months | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Not Known

14. Informant (Address): P. W. Pace, Burley Ida

15. Filed 12-10-, 1930 F. H. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 5 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 5, 1930, to Sep. 5, 1930, that I last saw him alive on Sep. 5, 1930, and that death occurred, on the date stated above, at 9:45 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto Collision with wagon of Poles Pole passing through liver & diaphragm
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Joseph Freinstad M. D.
....., 19.... (Address) Burley Ida.

19. Place of Burial, Cremation, or Removal: Burley Ida | Date of Burial: Sept. 6 1930

20. Undertaker: D. E. Johnson | Address: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72373

PLACE OF DEATH
County of Minidoka
City of Heyburn

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Tolger Olsen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah J Olsen

6. DATE OF BIRTH (month, day and year) Nov. 12, 1850

7. AGE Years 79 Months 10 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER Ole Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Ranninghgle Patterson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Norway

14. Informant (Address) Burley Idaho Paul Olsen

15. Filed 10-6-, 1930. F. A. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 —, 1930, to Sept 13 —, 1930
that I last saw him alive on — Sept. 13 — 1930
and that death occurred, on the date stated above, at 12 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
— Chronic nephritis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) — Infection Prostate
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? — Place of death
Did an operation precede death? no Date of .....
Was there an autopsy? no —
What test confirmed diagnosis? — Laboratory
(Signed) G. H. Cooper M. D.
Sept. 19 — 1930 (Address) Burly, Ida

19. Place of Burial, Cremation, or Removal Heyburn Ida
Date of Burial Sept 16 1930

20. Undertaker D. E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED OCT 31 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72374

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Kise Imagawa 31

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE ~~Yellow~~ Brown
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gataro Imagawa

6. DATE OF BIRTH (month, day and year) June 20 1888

7. AGE Years 42 Months 2 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Japan

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Sio Isigaki
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Japan

14. Informant (Address) G. Imagawa Burley Ida

15. Filed 10-15-, 1930 E. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 18 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-1-, 1927, to Sept-18, 1930
that I last saw her alive on Sept-17-, 1930
and that death occurred, on the date stated above, at 12:40 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? — Dont Know
Did an operation precede death? no Date of .....
Was there an autopsy? — no —
What test confirmed diagnosis? — Laboratory
(Signed) G. H. Cooper, M. D.
Sept 19, 1930 (Address) Burley, Ida

19. Place of Burial, Cremation, or Removal Burley Ida — Date of Burial Sept 20 1930

20. Undertaker D. E. Johnson — Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

RECEIVED OCT 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72376

PLACE OF DEATH

County of Cassia
City of Albion

CERTIFICATE OF DEATH

Registration District No. 119
Primary Registration District No. 2198
(No. .....)
Local Registrar's No. .....

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ellen Jane Boosinger

(a) Residence. No. ..... St. .....
(Usual place of abode.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State.)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F.	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Martin John Boosinger

6. DATE OF BIRTH (month, day and year) April 16, 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	3	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS

10. NAME OF FATHER John D Shafer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Markey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant J. M. Boosinger
(Address) Albion Idaho

15. Filed Oct 10, 1930 E. E. Slater
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18, 1930, to July 28, 1930, that I last saw her alive on July 18, 1930, and that death occurred, on the date stated above, at 6:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Intrinsic Nephritis

About (duration) 12 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. 15 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) [illegible] M. D.
..... 19..... (Address) [illegible]

19. Place of Burial, Cremation, or Removal	Date of Burial
Albion Ida.	July 30 1930

20. Undertaker D. E. Johnson Burley
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72377

PLACE OF DEATH

County of Clearwater

City of Orofino,

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 76

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

77

2. FULL NAME Samuel Berten Baldwin

(a) Residence. No. ..... St. Stites, Idaho
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of unascertained

6. DATE OF BIRTH (month, day and year) August 26, 1893

7. AGE: 37 Years: 37 Months: 2 Days: 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work General laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Seneca, Missouri

PARENTS

10. NAME OF FATHER W. H. Baldwin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Nancy Jane Robbins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Records, Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed 11/30, 19.. W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27, 1930, to October 29, 1930

that I last saw him alive on October 29, 1930

and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion of manic depressive psychosis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? Prior to admission

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) John Irvine McKelway, M. D.

October 29, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Stites Ida. Date of Burial: 19

20. Undertaker: Geo Trenary Address: Kooskia

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72378

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 75

(No. 204)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter A. Knapp

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) L

PARENTS

10. NAME OF FATHER L

11. BIRTHPLACE OF FATHER (city or town) (State or Country) L

12. MAIDEN NAME OF MOTHER L

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) L

14. Informant W. A. Shaw Coroner
(Address) Orofino Ida

15. Filed 11/29, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h... alive on ....., 19....
and that death occurred, on the date stated above, at 5:30 P m.
The CAUSE OF DEATH* was as follows:

Found Dead in Bed Natural
Heart Disease
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner, ~~M. D.~~
Oct 28, 19.... (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Oct 30 19
20. Undertaker W. A. Shaw	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72379

PLACE OF DEATH

County of Clearwater
City of Orofino - da

CERTIFICATE OF DEATH

Registration District No. 90
Primary Registration District No. 2187 Local Registrar's No. 44
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Sidney R. L. Allard

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 12 1925

7. AGE Years 5 Months Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stites Ida

PARENTS

10. NAME OF FATHER J. C. Irving Allard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missoula Mont
12. MAIDEN NAME OF MOTHER Mabel G. Hannaford
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mason City Nebr.

14. Informant (Address) X C. Allard

15. Filed 11/31, 1930 W. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22, 1930, to Oct 3, 1930
that I last saw him alive on Oct 3, 1930
and that death occurred, on the date stated above, at 5:00 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia - following - whooping Cough
..... (duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Dysentery.
..... (duration) — yrs. — mos. 12 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A. B. Pappenhagen M. D.
Oct. 14, 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal X Orofino
Date of Burial X Oct 6 1930

20. Undertaker X Address
[illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED NOV 3 1930

DO NOT WRITE IN THIS SPACE
State File No. 72380

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Keyrwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2174 Local Registrar's No. 123
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** Julius Steiner

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	White	M

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ~~Julius~~ Cordelia Steiner

6. DATE OF BIRTH (month, day and year) June 17 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Swiss
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Swiss

14. Informant Amil Schuster
(Address)

15. Filed Oct 14, 19 V. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th, 1929, to 10-12, 1930
that I last saw him alive on May 10th, 1930
and that death occurred, on the date stated above, at 12:10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma

Probably several years

(duration) yrs. mos. ds.

CONTRIBUTORY ✓
(Secondary)

✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms.

(Signed) J. J. Robertson M. D.
9-2, 1930 (Address) Orofino, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Faulkner Ida	Oct 15 19

20. Undertaker
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72381

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 72
(No.) 11 D
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry R. Pinson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Vivian Pinson

6. DATE OF BIRTH (month, day and year) April 21st 1902

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barbour
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Walter Sewell

9. BIRTHPLACE (city or town) (State or country) Cameron West Virginia

PARENTS

10. NAME OF FATHER W. L. Pinson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fort Gay West Va
12. MAIDEN NAME OF MOTHER Susan Farley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft Gay W Va

14. Informant W D Pinson
(Address)

15. Filed Oct 14, 19 H. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5th, 1930, to 10-5-, 1930 that I last saw h.kkm alive on 10-5-, 1930 and that death occurred, on the date stated above, at 2 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestinal Flu

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) ✓
(duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. F. Robinson, M. D.
10-14, 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Oct 14 19
20. Undertaker W D Pinson	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECD NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72382

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 71

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1a

2. FULL NAME Thomas Dempsey

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
About	63			hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) ✓
(State or country)

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) ✓
(State or Country)

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant Nelson Hospital
(Address) Orofino

15. Filed 10/11, 19.... W. A. Sloan
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Oct. 9, 1930
that I last saw ~~her~~ alive on Oct. 7, 1930
and that death occurred, on the date stated above, at 10:00 p.m.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) ..... yrs. ..... mos. 20 ds.

CONTRIBUTORY (Secondary) Myocarditis, acute

Dilatation heart (duration) ..... yrs. ..... mos. 10 minutes ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Typical.

(Signed) R. V. Hopkins, M. D.
Oct. 11, 1930 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	10/11 19
20. Undertaker	**Address**
W. A. Sloan	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72383

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157

Local Registrar's No. 70

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ivan Brake Goforth

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 47			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) —

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Louis Martin
(Address) Orofino Ida

15. Filed 11/6, 19.... H A Sloan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5 19.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Oct 5, 1930
that I last saw h[illegible] alive on Oct. 5, 1930
and that death occurred, on the date stated above, at 3:00 a.m.
The CAUSE OF DEATH* was as follows:

Gun-shot wound-accidental

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Alcoholic delerium tremens (duration) ... yrs. ... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of minor 10/3/30
Was there an autopsy? No
What test confirmed diagnosis? Clinical + Operative
(Signed) C. S. Hopkins, M. D.
10/6/30, 19.... (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Oct 7 19
20. Undertaker	Address
H A Sloan	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72384

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 65

(No. 115) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME ~~Female Baby~~ Donna Jeane Grimm

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 14th 1926

7. AGE — Years: 4 | Months: 3 | Days: 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Lewiston Ida
(State or country)

PARENTS

10. NAME OF FATHER Vernon Grimm
11. BIRTHPLACE OF FATHER (city or town) Minneapolis
(State or Country) Minn.
12. MAIDEN NAME OF MOTHER Bonnie Johnson
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Mont.

14. Informant Vernon Grimm
(Address) Orofino

15. Filed 11 6, 19.... W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 1st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1930 to Oct 1, 1930
that I last saw her alive on 10-1, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows: Ileo-Colitis - Intestinal Flu

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) ✓
(duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) H. E. Robertson M. D.
10-3, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino — Date of Burial: Oct 3rd 1930
20. Undertaker: W. D. Pinson — Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72385

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 6F

188e

2. FULL NAME Lavar Larson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 10 1912

7. AGE Years 17 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Sanford Larson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Syra Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Sanford Larson
(Address) Pierce

15. Filed 11/5, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 3, 1930
that I last saw him alive on Oct. 3, 1930
and that death occurred, on the date stated above, at 9:00 P. m.
The CAUSE OF DEATH* was as follows:

Automobile accident
Rupture small intestine Rupture urethra (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Oct. 3, 1930
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) R. J. Hopkins M. D.
Oct. 4, 1930 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pierce Ida
Date of Burial: 11/5 19

20. Undertaker: W. A. Shaw
Address: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72386

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 67
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1930

2. FULL NAME Phyllis Clawson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Femal	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 24 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	14			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Nathan
11. BIRTHPLACE OF FATHER (city or town) Emma Holiday
(State or Country)
12. MAIDEN NAME OF MOTHER Idaho
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Chas Long
(Address) Pierce Ida

15. Filed 11/3, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 2 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 11. P m.

The CAUSE OF DEATH* was as follows:
Accidental killed in auto wreck
car left road went down bank
broke neck and three ribe

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. A. Shaw Coroner, ~~M. D.~~
11/3, 1930 (Address) Orofin

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pierce Ida	Oct 5 19
20. Undertaker	**Address**
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72387

PLACE OF DEATH
County of Custer
City of Stanley

Registration District No. 108
Primary Registration District No. 2186
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 108

131

2. FULL NAME Jacob Roy Chapin
(a) Residence. No. Stanley Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ___ yrs. 2 mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary R. Chapin

6. DATE OF BIRTH (month, day and year) March 27, 1891

7. AGE 49 Years | Months 7 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Flour Miller
(b) General nature of industry, business, or establishment in which employed (or employer) Flour Mills
(c) Name of employer St Anthony Flour Mills

9. BIRTHPLACE (city or town) (State or country) Minneapolis Kansas

PARENTS
10. NAME OF FATHER Eugene L. Chapin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sharon ~~Iowa~~ Wis.
12. MAIDEN NAME OF MOTHER Eva A Kimball
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tripoli Iowa

14. Informant Ellis L. Chapin
(Address) Stanley Idaho

15. Filed Oct 31, 1930 Edna McKinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 - 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20, 1930, to 10-27, 1930
that I last saw him alive on 10-27, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
uremia
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Acute Brights Disease
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E. W. H., M. D.
10/28, 1930 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Blackfoot, Idaho Grove City Cemetery
Date of Burial 19

20. Undertaker E. J. Peck
Address Blackfoot.

RECEIVED NOV 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72388

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 109
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Alice Catherine Cobble
(a) Residence. No. Challis, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Newton William Cobble

6. DATE OF BIRTH (month, day and year) Sept 3, 1886

7. AGE Years 43 Months 1 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Neosho Mo
(State or country) Newton County Mo

PARENTS
10. NAME OF FATHER Pete Beck
11. BIRTHPLACE OF FATHER (city or town) Neosho Mo
(State or Country) Newton County Mo.
12. MAIDEN NAME OF MOTHER Emily Sharp
13. BIRTHPLACE OF MOTHER (city or town) Cassville Mo
(State or County) Green County Mo

14. Informant (Address) N. W. Cobble Challis Idaho

15. Filed Oct. 23, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1930, to , 19
that I last saw her alive on Oct 13, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Appendix

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. L. Kirtley, M. D.
11/6, 1930 (Address) Challis Ida

19. Place of Burial, Cremation, or Removal Challis
Date of Burial Oct 23 1930

20. Undertaker J. L. Ebberts
Address Challis Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72389

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Elmore
City of Glenns Ferry Registration District No. 35
Primary Registration District No. 2021 Local Registrar's No. 492
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** David A Kelly
(a) Residence. No. Glenns Ferry Ida St
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed or divorced
HUSBAND of (or) ~~WIFE of~~ Ella Mae Kelly

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer None (County Charge)

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (city or ~~town~~) (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) Ella Mae Kelly Glenns Ferry Ida

15. Filed 10-28-30 Mrs Mary Sullivan Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to Oct. 15, 1930.
that I last saw him alive on Oct. 15, 1930.
and that death occurred, on the date stated above, at 6 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. W. Davis, M. D.
Oct. 15, 1930 (Address) Glenns Ferry Idaho

19. Place of Burial, Cremation, or Removal: Glenns Ferry Ida — Date of Burial: 10-15 1930

20. Undertaker: G. C. Zacher — Address: Mt Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72390

PLACE OF DEATH

County of Elmore
City of Glenns Ferry

CERTIFICATE OF DEATH

Registration District No. 35
Primary Registration District No. 2021 . Local Registrar's No. .....
(No. .....)
(If ~~death~~ occurred in a hospital or institution, give its name instead of street and number.)

1880

2. **FULL NAME** Tilford Brickey
(a) Residence. No. O S L Emergency Hospital St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer-Farm Hand Last work was on Railroad section at Hammett Ida
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer O S L R R

9. BIRTHPLACE (city or town) (State or country) Manes Missouri

PARENTS

10. NAME OF FATHER Preston Brickey (Dec)
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Altha Alumbaugh
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) Mrs A T Alumbaugh Deeth Nevada

15. Filed 10-23, 1930 Mrs. Mary Sullivan Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hit by O S L train # 18 at Mile Post 385½ west of Hammett
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Elmore Co
(Signed) G C Zacher Coroner M.D.
10-21-, 1930 (Address) Mt Home Ida

19. Place of Burial, Cremation, or Removal Mt. Grove Mo
Date of Burial 19

20. Undertaker G. C Zacher
Address Mt Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72391

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Elmore
City of 6 East of King Hill Ida

Registration District No. 35
Primary Registration District No. 2621
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Joseph Howard McCoy
(a) Residence. No. Battle Mountain Nev. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

1926

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence McCoy.

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner. Gold.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Richard McCoy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ken.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ken.

14. Informant (Address) Bart McCoy. Battle Mountain Nev.

15. Filed Oct 1, 1930 Mrs Mary Sullivan Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 6th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 8 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto Accident
Rib Punctured
Heart.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) G. S. Zachen Coroner, M. D.
10-7, 1930 (Address) Mt. Home Ida

19. Place of Burial, Cremation, or Removal: Battle Mt. Nev. | Date of Burial 19

20. Undertaker: G. S. Zachen. | Address: Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

REC'D NOV 5 1930

STATE OF ID.....
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72392

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Elmore
City of Glenns Ferry Registration District No. 30
Primary Registration District No. 3031 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** (Mrs) Sarah McCabe

(a) Residence. No. ..... Glenns Ferry Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John McCabe

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs, or ..... min.
	57	11	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Ora Ontario Canada

PARENTS

10. NAME OF FATHER John Graham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ora Ontario Canada
12. MAIDEN NAME OF MOTHER Gilcras
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant John McCabe
(Address) Glenns Ferry Ida

15. Filed 10-15, 1930 Mrs Mary Sullivan Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1930, to October 13, 1930
that I last saw her alive on October 13, 1930
and that death occurred, on the date stated above, at 11 25/60 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina pectoris

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J W Davis, M. D.
....., 19..... (Address) Glenns Ferry Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Glenns Ferry Ida	10-16 1930
20. Undertaker G C Zacher	Address Mt Home

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RE NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72393

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 69

PLACE OF DEATH
County of Franklin
City of Preston
(No.) 13
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Peterson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widoewd

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Caroline Peterson

6. DATE OF BIRTH (month, day and year) May I3 I862

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	5	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none of late
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweedan

PARENTS

10. NAME OF FATHER Jno Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Catherine Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Grace Johnson
(Address) Preston

15. Filed 10/18/ 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1930, to Oct 16 1930
that I last saw h[illegible] alive on Oct 16 1930
and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:
Septicaemia from prostatic infection
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) G. W. Stalis, M. D.
Oct 16 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	Oct I9 30
20. Undertaker M. W. Hendricks	Address Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RE NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72394

PLACE OF DEATH

County of Franklin
City of Clifton
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 73.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

111a

2. FULL NAME Riley Davis.

(a) Residence. No. Clifton Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	~~M~~

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 26, 1851

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER James Hard Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Thurman Iowa.
12. MAIDEN NAME OF MOTHER Elizabeth Gordon.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant Orson Koford.
(Address) Clifton, Ida.

15. Filed 10/25, 1930. C. F. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 10/23/ 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:
Ulcer of Stomach
Hemorrage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. L. Clark M.D. Coroner
10/25/, 1930. (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
~	~

20. Undertaker	Address
None	~

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72395

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 70

(No. 24)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruby Hellen Falkman

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of David J Falkman

6. DATE OF BIRTH (month, day and year) May 19 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	5	20	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Harry H. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Edna Moffett

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant David J. Falkman

(Address) Preston Idaho

15. Filed 10/31/30, 19.....

C. R. Curtis
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-27, 1930, to 10-29, 1930

that I last saw her alive on 10-29 1930

and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Meningo-Coccus Meningitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Preston Idaho

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Aut. Post.

(Signed) C. R. Curtis, M. D.

....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah	Nov 2 30

20. Undertaker M. N. Hendricks

Address Preston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

NOV 6 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72396

PLACE OF DEATH

County of Franklin

City of Whitney

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 72

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ann Weaver

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
fe,male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Gilbert E. Weaver

6. DATE OF BIRTH (month, day and year) Dec 27 30 1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	11 8	29 3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Ogden Utah
(State or country)

PARENTS

10. NAME OF FATHER Daniel Gamble

11. BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country)

12. MAIDEN NAME OF MOTHER Sarah Yeats

13. BIRTHPLACE OF MOTHER (city or town) Engkand
(State or Country)

14. Informant Mr. Gilbert E. Weaver
(Address) Whitney

15. Filed 10/31/30, 19.....

A. P. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
10 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
10-1, 1929, to 10-30, 1930
that I last saw h[illegible] alive on 10-30 1930
and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

~~Apoplexy~~ Pneumonia
Paralysis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. P. Cutler, M. D.

....., 19..... (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney Idaho	Nov 3 0 19

20. Undertaker	Address
M. W. Hendricks	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72397

PLACE OF DEATH

County of Franklin

City of Minkerend

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 71

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Elizabeth Barfus

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jno Barfus

6. DATE OF BIRTH (month, day and year): Oct 27 1844

7. AGE: Years 86 | Months | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Switzerland

PARENTS

10. NAME OF FATHER: Jno Ashbocher

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Wisman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Switzerland

14. Informant: Mrs. Jno Young
(Address) Thatcher Idaho

15. Filed 10/31/30 19.... A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-1, 1930 to 10-29, 1930

that I last saw her alive on 10-28, 1930

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) A. R. Cutler, M. D.

....., 19.... (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho | Date of Burial: Oct 30 1930

20. Undertaker: M. W. Hendricks | Address: Preston

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72398

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 66.

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Oze Ozeis Crockett

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ruth Crockett

6. DATE OF BIRTH (month, day and year) Nov 29 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	9	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) was a farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payson Utah

PARENTS

10. NAME OF FATHER Alvin Crockett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Mary S. Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Hampshire

14. Informant Mrs Ruth Crockett
(Address) Preston Idaho

15. Filed 10/4/, 1930 C.R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 2 (Day) 30 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Oct 2, 1930
that I last saw him alive on Oct 2, 1930
and that death occurred, on the date stated above, at 11 40 a m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) 7 mos. 40 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Symptoms
(Signed) Eugene Hanley, M. D.
Oct 2, 1930 (Address) Preston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Logan Utah Oct	5 30 19

20. Undertaker M.W. Hendricks Address Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25-M. 1-19. NOV 6 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Franklin

City of Presto , Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

State File No. 72399

Local Registrar's No. 68.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melba Fellows

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1930 (Year)

7. AGE: 30 Min. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Franklin

10. NAME OF Father: Orin V Fellows

11. BIRTHPLACE OF FATHER (State or Country): Franklin

12. MAIDEN NAME OF MOTHER: Selma Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Franklin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orin V Fellows

(Address) Preston, Ida

15. Filed 10/14/30 19 A. R. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: Oct (Month) 9-1930 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1930, to Oct 9 1930, that I last saw her alive on Oct 9 1930, and that death occurred on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows: Premature Birth. Lived - 30 minutes

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Placenta Previa

(Duration) ..... yrs. ..... mos. 30 min ds.

(Signed) Eugene Horley M. D.

Oct 9 1930 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston, Ida

DATE OF BURIAL: Oct 11-30 19

20. UNDERTAKER: Sexton W. E. Fellows

ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72400

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 67

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159B

2. FULL NAME Lyle Loraine Manning

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: whits

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 26 30

7. AGE Years: Months: 1 Days: 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS

10. NAME OF FATHER: Lyle Manning

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Prston Idaho

12. MAIDEN NAME OF MOTHER: Loraine Hansen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Logan

14. Informant: Mrs Manning
(Address) Preston

15. Filed 10/4/, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct - 2 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept - 29, 1930, to Oct 2 -, 1930 that I last saw him alive on Oct 2 -, 1930 and that death occurred, on the date stated above, at 9 50 a m.

The CAUSE OF DEATH* was as follows:

Inanition

..... (duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (Secondary) Congenital Valvular disease of Heart (duration) ..... yrs. ..... mos. 30 ds.

18. Where was disease contracted if not at place of death? Salt Lake City Utah

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. W. States, M. D.

Oct 2 -, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Preston Idaho — Date of Burial: Oct 4 30

20. Undertaker: M. W. Hendricks — Address: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72401

PLACE OF DEATH
County of Fremont
City of Wilford

Registration District No. 79
Primary Registration District No. 2177
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 358

88a

2. FULL NAME Wilburn Welker.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 10th 1857

7. AGE Years: 73. Months: Days: If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wilard Utah

PARENTS

10. NAME OF FATHER James Wilburn Welker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.
12. MAIDEN NAME OF MOTHER Annie Pugh Tenn.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant Elmo Welker
(Address) St Anthony Box 75

15. Filed 11/11, 1930 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7th, 1930, to Nov. 7, 1930
that I last saw him alive on Nov. 7th 1930
and that death occurred, on the date stated above, at 10:30 P.M.
The CAUSE OF DEATH* was as follows:
Chr. Endocarditis
..... (duration) 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Broncho-Pneumonia
..... (duration) ..... yrs. ..... mos. 11 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Findings
(Signed) P. M. Keller, M. D.
Nov. 9, 1930 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford Ida. Date of Burial: Nov. 12 1930

20. Undertaker: Vern J Keller Address: Rexburg

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72402

PLACE OF DEATH

County of Fremont

City of St. Anthony

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 357

(No.) 111a

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Milinda Packer

(a) Residence. No. St. Anthony, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
(or) WIFE of Frank A. Packer

6. DATE OF BIRTH (month, day and year) May 4th, 1883

7. AGE	Years	Months	Days	If LESS than 1 day,
	47	6	xx	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cotton-wood, Utah.

PARENTS

10. NAME OF FATHER John H. Barnes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Bethiah Wilkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Frank A. Packer

(Address) St. Anthony, Idaho.

15. Filed Nov. 5th, 1930 W. M. Hansen
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 3, 1930, to Nov. 4, 1930

that I last saw her alive on Nov. 4, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Gastric Ulcer.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Post operative Collapse

(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of About Oct 20.

Was there an autopsy? No

What test confirmed diagnosis? Blood & Operation

(Signed) P. M. Fellows, M. D.

11-4-, 1930 (Address) St. Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho.	Nov. 7th, 1930

20. Undertaker	Address
	St. Anthony, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72403

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 356

PLACE OF DEATH
County of Fremont
City of St. Anthony
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herman Grimes

(a) Residence. No. Portales New Mexico St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 20	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hobart & Merrill

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER H. A. Grimes

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Edward Farmer
(Address) Texas

15. Filed Oct 21, 1930 W. W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1930, to only, 19..., that I last saw h. in alive on not at all, 19..., and that death occurred, on the date stated above, at about 8:30 p.m.

The CAUSE OF DEATH* was as follows:
fractured skull
(automobile accident)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. A. Ellison M. D.
Oct. 23, 1930 (Address) St. Anthony Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation, or~~ Removal: Portales New Mexico | Date of Burial 19

20. Undertaker W. W. Hansen | Address St. Anthony Ida.

N. B.—Every item of information should be carefully supplied: AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72404

PLACE OF DEATH

County of Fremont
City of St. Anthony Idaho
Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 355

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

98 B

2. FULL NAME Mary Hunt Black

(a) Residence. No. .... St. Anthony Idaho .... St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. .... yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of George David Black

6. DATE OF BIRTH (month, day and year) July 12 - 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	85	2	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....

9. BIRTHPLACE (city or town) (State or country) Hancock County Ills

PARENTS

10. NAME OF FATHER Jefferson Hunt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Cecil Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant Mrs. J. Black
(Address) Mc. Common Idaho

15. Filed Sept. 29, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 29, 1930
that I last saw her alive on Sept. 26, 1930
and that death occurred, on the date stated above, at 6:30 a. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis.
.... (duration) 2 yrs. .... mos. .... ds.
CONTRIBUTORY (Secondary) General Exaustion.
.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? Heart Exam.
(Signed) P. M. Keller, M. D.
Sept. 29, 1930 (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wilford Cemetery	Oct. 1 1930
20. Undertaker	Address
W. M. Hansen	St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72405

Registration District No. 99
Primary Registration District No. 2177
Local Registrar's No. 354

PLACE OF DEATH
County of Fremont
City of St. Anthony
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John G. McCollum

(a) Residence: No. St. Anthony Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1000

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Irene Harris McCollum

6. DATE OF BIRTH (month, day and year) June 22-1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	3	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country) Dequoin Ill.

PARENTS
10. NAME OF FATHER George McCollum
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER Lucinda Wells
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant James McCollum
(Address) St. Anthony Idaho

15. Filed Sept. 26 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1930, to Sept. 25, 1930
that I last saw him alive on Sept. 25, 1930
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(duration) yrs. mos. 23 ds.
CONTRIBUTORY (Secondary) Exposure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) P. M. Kelly M. D.
9-25 1930 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverview Cemetery	Sept. 28-30
20. Undertaker	Address
W. M. Hansen	St. Anthony Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72406

PLACE OF DEATH
County of Fremont
City of St. Anthony

Registration District No. 99
Primary Registration District No. 2177

Local Registrar's No. 352

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

490

2. FULL NAME Annie Mellissia Anderson

(a) Residence. No. St. Anthony Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Carl Anderson

6. DATE OF BIRTH (month, day and year) May 30-1904

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	4	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St. Anthony Idaho

PARENTS

10. NAME OF FATHER Joseph W. Kershaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Africa
12. MAIDEN NAME OF MOTHER Julia Ann Cliff
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City Utah

14. Informant Carl Anderson
(Address) St. Anthony Idaho

15. Filed Sept. 20, 1930 C.W. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10, 1930 to Sept. 19, 1930
that I last saw her alive on Sept. 19, 1930
and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:
Acute endocarditis.

(duration) yrs. 1 mos. — ds.
CONTRIBUTORY (Secondary) Acute Nephritis.
(duration) yrs. mos. 15 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Heart & Kidneys
(Signed) B. M. Kelly M. D.
9-19-, 1930 (Address) St Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Milford Cemetery	Sept. 22 1930

20. Undertaker W. M. Hansen Address St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72407

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rachel Francis Thomas

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 16 - 1871

7. AGE Years: 59 Months: 1 Days: 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hawkins County Tenn

PARENTS
10. NAME OF FATHER: Absolem Caldwell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ebbington Virginia
12. MAIDEN NAME OF MOTHER: Mary Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Virginia

14. Informant (Address): Jul C. Thomas Harper Oregon

15. Filed 10/29, 1930 J L Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Oct 25, 1930
that I last saw her alive on Oct 25, 1930
and that death occurred, on the date stated above, at 4 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
myocardial insufficiency

several (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) R N [illegible] M. D.
10/29, 1930 (Address) .....

19. Place of Burial, Cremation, or Removal: Emmett Idaho
Date of Burial: 10/29 1930

20. Undertaker: C D Bucknum
Address: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72408

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. ....
Primary Registration District No. 6 Local Registrar's No. ....
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Smith

(a) Residence. No. .... St. ....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. .... yrs. .... mos. .... ds. How long in U. S. if of foreign birth? .... yrs .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Fem	white	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 17 - 1855

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
75	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9. BIRTHPLACE (city or town) .... (State or country) England

PARENTS
10. NAME OF FATHER Thomas Hunter
11. BIRTHPLACE OF FATHER (city or town) .... (State or Country) England
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) .... (State or County) Not Known

14. Informant (Address) Williams Smith

15. Filed 10/10, 1930 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
for two years or more, 19.... to 19....
that I last saw her alive on Oct 9th, 1930
and that death occurred, on the date stated above, at 3:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
involving Gall Ducts

.... (duration) ✓ yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) ....
.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? Emmett Ida
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. L. Reynolds, M. D.
10/10, 1930 (Address) Emmett Ida

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 10/12 1930
20. Undertaker: C. D. Buckner — Address: ....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 3 · 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72409

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. 4
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie E. Grahom

(a) Residence. No. ..... St. 70
(Usual place of abode.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs ..... mos. ..... ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Andrew Grahom

6. DATE OF BIRTH (month, day and year) Sept 28-1885

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	—	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Atchison Kansas

PARENTS

10. NAME OF FATHER Jesse M. Croft
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Emma Richards
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Mrs Jake Ritter

15. Filed 10/24, 1930 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Oct 20, 1930, to Oct 22, 1930, that I last saw h-y alive on Oct 20, 1930 and that death occurred, on the date stated above, at 9 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Encephalitis Lethargica
(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. L. Reynolds, M. D.
10/24, 1930 (Address) Emmett Ida

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 10/25 1930

20. Undertaker: C. W. Buckman — Address: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19 RECEIVED NOV 7 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72410

Local Registrar's No. 137

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roger Hiram Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	married

6. DATE OF BIRTH: Feb. 12th 1879 (Month) (Day) (Year)

7. AGE: 51 Yrs. 8 Mos. 21 ds. | IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chief Clerk.
(b) General nature of industry, business or establishment in which employed (or employer): Mechanical Div. Canal Zone. Gov.

9. BIRTHPLACE (State or Country): Quitman Miss.

10. NAME OF Father: James P. Adams

11. BIRTHPLACE OF FATHER (State or Country): Quitman Miss.

12. MAIDEN NAME OF MOTHER: Jane Herring

13. BIRTHPLACE OF MOTHER (State or Country): Quitman Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Roger H Adams
(Address) Gooding, Ida.

15. Filed Nov 3 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH 101A

16. DATE OF DEATH: Nov 2nd 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1930. to Nov 2 1930, that I last saw h~~e~~ alive on Nov 2 1930, and that death occurred on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.

11/3 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Gooding. Ida	11-6-1930

20. UNDERTAKER	ADDRESS
Ella White	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-10. RECEIVED NOV 7 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72411
Local Registrar's No. 138

1. PLACE OF DEATH

County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 24
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Harrington Whittaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word)

6. DATE OF BIRTH: July (Month) 4th (Day) 1840 (Year)

7. AGE: 90 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Perry, Illinois

10. NAME OF Father: Harlin Harrington

11. BIRTHPLACE OF FATHER (State or Country): Sutton, Mass.

12. MAIDEN NAME OF MOTHER: Katherine Hagaman

13. BIRTHPLACE OF MOTHER (State or Country): Hagaman Mills, N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Katherine Hudelson
(Address) Gooding Ida

15. Filed Nov 3 1930 J H Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH 1900

16. DATE OF DEATH: Nov (Month) 2nd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1930, to Nov 2 1930, that I last saw him alive on Nov. 2 1930, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.

11/3 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Perry, Illinois
DATE OF BURIAL: 11-10- 1930

20. UNDERTAKER: Ella White
ADDRESS: Twin Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A-25M. 1-19.

NOV 7

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No.

(No. ..... St.)

State File No. 72412 139-

Local Registrar's No. ~~136~~

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Kasch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word)

6. DATE OF BIRTH: Sept. (Month) 26th (Day) 1842 (Year)

7. AGE: 88 Yrs. ..... Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF Father: — Kasch

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jno Casch
(Address) Gooding Ida

15. Filed 10/20 1930 J H Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH: Oct. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1930, to Oct 19 1930, that I last saw him alive on Oct 1 1930, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Heart disease
Mitral Insuf.
Chronic
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.
10/20 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Elmwood Cem.

DATE OF BURIAL: 10-20-1930

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72413

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
(No.) Local Registrar's No.

11B

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marlin Alvis Pollan

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) June 19th 1927

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
3 years	3	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville Idaho

PARENTS

10. NAME OF FATHER Alvis B Pollan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eastern Oklahoma
12. MAIDEN NAME OF MOTHER Ruth A Gram
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grangeville Idaho

14. Informant Alvis B Pollan
(Address) Stites Idaho

15. Filed Oct 19, 1930 J M Rebekkens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 18th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1930, to Oct 18th, 1930
that I last saw him alive on Oct 16th, 1930
and that death occurred, on the date stated above, at p m.
The CAUSE OF DEATH* was as follows:
Summons Flu with accent on intestines -

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Typic fever
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs Symptoms
(Signed) H W Whitworth, M. D.
Oct 19th, 1930 (Address) Stites Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hayden — Date of Burial: Oct 19 1930
20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72414

Local Registrar's No. 304

PLACE OF DEATH

County of Idaho

City of Stites

Registration District No. 106

Primary Registration District No. 2184

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sylvia Bell Tippett

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Dec 25th 1925

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Guy Tippett

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hoppner Oregon

12. MAIDEN NAME OF MOTHER Golda Stem

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wallowa Oregon

14. Informant Guy Tippett

(Address) Stites Idaho

15. Filed Oct-4, 1930 J M Verbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 2nd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1st, 1930, to Oct 2nd, 1930
that I last saw her alive on Oct 2nd, 1930
and that death occurred, on the date stated above, at 6/30 a. m.
The CAUSE OF DEATH* was as follows:

Summer Flux - Acute intestinal form

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W Wentworth, M. D.

Oct 2, 1930 (Address) Stites Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Enterprise Oregon	
20. Undertaker Geo Tenney	Address Troskia Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REGISTERED OCT 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72415

PLACE OF DEATH
County of Idaho
City of Stites

Registration District No. 106
Primary Registration District No. 2184
Local Registrar's No. 303

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Marie Grace Lytle

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6. DATE OF BIRTH (month, day and year): Apr 9-1930

7. AGE — Years: — Months: 5 Days: 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Stites Idaho

PARENTS

10. NAME OF FATHER: Ernest Lytle
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Jo Davis Co. Ill.
12. MAIDEN NAME OF MOTHER: Grace Muntala Gunlin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Clearwater Idaho

14. Informant: Ernest Lytle
(Address): Stites Idaho

15. Filed Oct 1, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 28th, 1930, that I last saw h[illegible] alive on Sept 27th, 1930, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:
Summer Flu -
Acute Intestinal form
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symp

(Signed) H. W Westmark, M. D.
Sept 27, 1930 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Clearwater Idaho — Date of Burial: Sept 28 1930
20. Undertaker — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D OCT 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72416

Registration District No.
Primary Registration District No.
Local Registrar's No. 304

PLACE OF DEATH
County of Idaho
City of Stites
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lee Ernest Lyste

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6. DATE OF BIRTH (month, day and year) Apr 9 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	5	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stites Idaho

PARENTS

10. NAME OF FATHER Ernest Lyste
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jo Davis Co Illinois
12. MAIDEN NAME OF MOTHER Grace Montala Gunkle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clearwater Idaho

14. Informant Ernest Lyste
(Address) Stites Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930, to Sept 27, 1930, that I last saw him alive on Sept 27 1930 and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:
Summary Hem
Acute Intestinal toxa
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs
(Signed) H W Whitworth, M. D.
Sept 27 1930 (Address) Stites

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clearwater Idaho	Sept 28 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13 REC'D NOV 3 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho — Registration District No. 103

City of Cottonwood — Primary Registration District No. 2181

(No. ....., ... St.)

File No. 7241

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 19 (Day) 1876 (Year)

7. AGE: 54 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Valmer Hanson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Catherine R. Hanson
(Address) Grangeville, Idaho.

15. Filed 11-1-1930 B. Chipman Local Registrar

MEDICAL CERTIFICATE OF DEATH

118 B

16. DATE OF DEATH: Oct (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18 1930, to Oct 30 1930, that I last saw her alive on Oct. 30 1930, and that death occured on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:
Death followed operation for Acute intestinal obstruction. Resection of two feet of ileum.
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr. M. D.
10/30 1930 (Address) Cottonwood, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Prairie View	10/22 1930
20. UNDERTAKER	ADDRESS
Vassar	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72418

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 27
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** Walter B Trueblood

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widow

6. DATE OF BIRTH (month, day and year) March 27, 1848

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs, or ....min.
	82	6	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Mt Pleasant Miss.
(State or country)

PARENTS

10. NAME OF FATHER Addison Trueblood
11. BIRTHPLACE OF FATHER (city or town) Ind
(State or Country)
12. MAIDEN NAME OF MOTHER Priscilla Thompson
13. BIRTHPLACE OF MOTHER (city or town)
(State or County)

14. Informant
(Address) Star Route Denny

15. Filed 11-1-, 1930. B Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Sept 18, 1930, that I last saw h— alive on Sept 17, 1930, and that death occurred, on the date stated above, at 2:9 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Enlarged Prostate
(Signed) B Chipman M. D.
9-19- 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	8-20- 1930
20. Undertaker	Address
Hancock Mtd Co	Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72419

PLACE OF DEATH.
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
(No. At Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

101a

2. FULL NAME Harry G. Vincent
(a) Residence. No. Grangeville Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ida Vincent

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 51, Months 4, Days 13. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Trader Man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston Idaho

PARENTS
10. NAME OF FATHER: Joseph Vincent
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Salem Mass.
12. MAIDEN NAME OF MOTHER: Elizabeth Leland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): R. I.

14. Informant: Ada Vincent
(Address) Lewiston Idaho

15. Filed 11-1-, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1930, to Oct 14, 1930
that I last saw him alive on Oct 14, 1930
and that death occurred, on the date stated above, at 7:00 P. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. 1 mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Tiny. Findings
(Signed) B. Chipman, M. D.
10-15-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Prairie View
Date of Burial: 10/16 1930

20. Undertaker: Vassar
Address: Grangeville

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 12 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 72420

Registered No. 16

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

County of Idaho

City of Cottonwood (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W. Murdock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Nov (Month) 5 (Day) 1849 (Year)

7. AGE: 80 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER John Murdock

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Hanna Hutchison

13. BIRTHPLACE OF MOTHER (State or Country) Boston Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elmer Taylor

(Address) Baker, Idaho.

15. Filed 9/19 1930

H. F. Orr
Local Registrar
per F.B.

SYMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

1000

16. DATE OF DEATH

Sept (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-11 1930, to 9-18 1930, that I last saw h... alive on 9-17- 1930, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Fractured femur

(Duration ..... yrs. ..... mos. 11 ds.

(Signed) G. A. Woodward M. D.

9-19 1930 (Address) Cottonwood, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Cemetery

DATE OF BURIAL: 9-20 1930

20. UNDERTAKER: Vassar.

ADDRESS: Lewiston, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 12 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 72421

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Cottonwood

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Klapprich

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 2 (Month) 17 (Day) 1850 (Year)

7. AGE: 80 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Jacob Klapprich

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry A Klapprich

(Address) Cottonwood Idaho

15. Filed Oct. 16 1930 — H. F. Orr Jr. M.D. Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 12 1930, to Oct 12 1930, that I last saw him alive on Oct. 12 1930, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

10/14 1930 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood, Ida. — DATE OF BURIAL: Oct. 14 1930

20. UNDERTAKER: Brower-Hamm — ADDRESS: Lewiston Ida.

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH. REC'D NOV 12 1930

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 72422

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donna Jean Gentry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. single (Write the word.)

6. DATE OF BIRTH. June (Month) 26th (Day) 1929 (Year)

7. AGE 1 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)... none

9. BIRTHPLACE (State or Country) Idaho U. S.

10. NAME OF FATHER Avery A. Gentry

11. BIRTHPLACE OF FATHER (State or Country) N. Carolina

12. MAIDEN NAME OF MOTHER Alma Goeckner

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Avery Gentry

(Address)

15. Filed Oct. 26 1930 W. F. Orr Local Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH Oct (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15 1930, to 10-24- 1930, that I last saw her alive on 10-24- 1930, and that death occured on the date stated above, at 7 30 p M.

The CAUSE OF DEATH* was as follows: Congenital heart lesion.

(Duration) Congenital. Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. L. Peterson M. D.

10-26 1930 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? at place of death

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Cottonwood

DATE OF BURIAL Oct 26 1930

20. UNDERTAKER [illegible]

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24658

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED NOV 14 1930

DO NOT WRITE IN THIS SPACE

State File No. 72424

PLACE OF DEATH

County of Jefferson

City of Rigby, Idaho.

CERTIFICATE OF DEATH

Registration District No. 98

Primary Registration District No. 2176 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Martha Almeda (Hill) Dickens

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of James E. Dickens

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
36	5	24	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) Lewisvill Idaho
(State or country)

PARENTS

10. NAME OF FATHER George W. Hill

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) England

12. MAIDEN NAME OF MOTHER Cordelia Harmon

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah.

14. Informant James E Dickens
(Address)

15. Filed 10/25 1930 A B Eskersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
Oct 1st, 1930, to Oct 20th, 1930,
that I last saw her alive on Oct 20th, 1930
and that death occurred, on the date stated above, at 10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
and intestines

.....(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted ✓ if not at place of death? .....

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. T. Anderson M. D.

10/25, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Rigby Idaho — Date of Burial: 10/27 1930

20. Undertaker A B Eskersell Rigby — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72425

RECEIVED NOV 14 1930

PLACE OF DEATH

County of Jefferson

City of Roberts.

Registration District No. 98

Primary Registration District No. 2176

Local Registrar's No. 1480

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Basil W. Campbell.

(a) Residence. No. St. Beach N. Dak.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Unknown.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Sheriff Rhodes. Rigby, Idaho.

15. Filed 10/22, 1930 A B Eskendall Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
—, 19..., to —, 19...
that I last saw him alive on 10/20/30, 19...
and that death occurred, on the date stated above, at 12:01 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Crushed beneath train at Roberts Ida
Instant (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Jos Taylor Coroner M. D.
10/22, 1930 (Address) Rigby, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Beach, N. Dak.	Oct 24 1930

20. Undertaker A B Eskendall Address Rigby, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED NOV 1 30

DO NOT WRITE IN THIS SPACE
State File No. 72426

PLACE OF DEATH
County of Bonneville
City of Rice Star Route
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

16/12

2. FULL NAME Bert Tyler Byington

(a) Residence. No. Rice Star Route St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 1hr 15 min ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Oct 19 - 30

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	0	0	15 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Rice Star Route.

9. BIRTHPLACE (city or town) (State or country) Rice Star Route.

PARENTS

10. NAME OF FATHER Bert Byington.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Annes Ida.
12. MAIDEN NAME OF MOTHER Alice Matilda Tyler.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Acon Ida.

14. Informant Bert Byington
(Address)

15. Filed 10/20, 1930 C. B. Eckersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19, 1930, to Oct 19, 1930
that I last saw him alive on Oct 19, 1930
and that death occurred, on the date stated above, at 4 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prolapse of cord.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. R. Abbott M. D.
Oct 19, 1930 (Address) Rice Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Annis Idaho	10/20 1930
20. Undertaker	Address
C. B. Eckersell	Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72427

RECEIVED NOV 14 1930

PLACE OF DEATH
County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1496

2. FULL NAME Donna Olsen.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Babe

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 1 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rigby, Idaho.

PARENTS

10. NAME OF FATHER Robert Henry Olsen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Eva Lee.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant (Address) R. W. Oliver Rigby, Idaho.

15. Filed 10/9, 1930 A B Eckersell Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 9, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to Oct 9, 1930, that I last saw her alive on Sept 10, 1930 and that death occurred, on the date stated above, at 5:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

(Defective from birth)
Bronchitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Defective engenitality

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? No Date of V
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. A. Anderson, M. D.
Oct 11, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Rigby, Idaho.	10/11 1930

20. Undertaker A B Eckersell Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72428

PLACE OF DEATH

County of Jerome
City of Eden

Registration District No.
Primary Registration District No.
(No.)

Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Richard Byron Beebout

(a) Residence. No. Eden Idaho R.F.D St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) March 19-1927

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
3	7	~~4~~ (4)	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Twin Falls Idaho.

PARENTS

10 NAME OF FATHER M. R. Beebout.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho.

12 MAIDEN NAME OF MOTHER Irene averett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Utah.

14 Informant Mrs. M. R. Beebout
(Address) Eden Idaho. R. F. D.

15 Filed 11-1, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
10 (Month) 22 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10-21, 1930, to 10-22, 1930, that I last saw h~~im~~ alive on 10-22, 1930, and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:
Poliomyelitis
(duration) yrs. mos. 18 hrs ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No. Date of —
Was there an autopsy? yes
What test confirmed diagnosis? Spinal puncture
(Signed) S. Hopper M. D.
10-22, 1930 (Address) Hazelton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida	10-23 1930
20. Undertaker White Mortuary	Address Twin Falls Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72429

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME John E. Fisher

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Ida Fisher

6. DATE OF BIRTH (month, day and year) 1865 - 1 - 7

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) General retail store
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Memphis Tenn.

PARENTS

10. NAME OF FATHER John E. Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Huldah Sawyer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant F. W. Fisher
(Address)

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 1930, to Oct 17, 1930
that I last saw him alive on Oct 17, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Intussusception
(duration) yrs. 2+ mos. + ds.
CONTRIBUTORY (Secondary) Chronic ulcerative colitis
(duration) 2 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? History & case
(Signed) W. W. Babcock, M. D.
, 19 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Cem. Harrison Ida	10-27 1930
20. Undertaker	Address
Corsed Funeral Home.	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72430

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

164

2. FULL NAME Margaret Lamb.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jas. Lamb.

6. DATE OF BIRTH (month, day and year) 1839-1-11

7. AGE Years 91 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Perth Scotland

PARENTS
10. NAME OF FATHER Peter Strang
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Galloway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland.

14. Informant Peter Lamb
(Address) Harrison. Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1930, to Oct. 20, 1930
that I last saw her alive on Oct. 6 1930
and that death occurred, on the date stated above, at 6:15 P m.
The CAUSE OF DEATH* was as follows:

Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Impacted fracture of hip with resulting confinement to bed.
(duration) yrs. 1 mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? ~~H~~
(Signed) H. W. Shryock, M. D.
Oct. 21, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72431

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Hulbert-Hoverson.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Helen Hoverson

6. DATE OF BIRTH (month, day and year) 1862-1-~~20~~22

7. AGE Years 68 Months 8 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) La Crosse Wis.

PARENTS

10. NAME OF FATHER Thom Hoverson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Dahl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Donald Hoverson
(Address) Elk River Ida.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1930, to Oct. 19, 1930
that I last saw him alive on Oct. 17, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:

Inanition
(duration) yrs. ~~2~~ mos. + ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis Chronic
(duration) 1 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Urinary findings.
(Signed) H W Shryock, M. D.
Oct. 18, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison Cem. Harrison Ida. Date of Burial 10-21-1930

20. Undertaker Cassedy Funeral Home Address Harrison Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72432

PLACE OF DEATH
County of Kootenai
City of ....
Registration District No. 126
Primary Registration District No. 2304
Local Registrar's No. 15

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Van Duesen

(a) Residence. No. Harrison St. Flats St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John A Van Duesen

6. DATE OF BIRTH (month, day and year) June 4th 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	5	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ont. Canada

PARENTS

10. NAME OF FATHER Clare
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs L. P. Tiffle
(Address) Coeur d Alene Idaho.

15. Filed Oct 8, 1930. H W Laycock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw her alive on ..., 19...
and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:
Saw her about 30 minutes after death - Reported to County Coroner - apparently Apoplectic -
Hearty dinner - Indulged excitement (duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) in quarrel with neighbor -
Death sudden - complained of severe headache - Was cyanotic - Distended abdomen (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? — Date of ...
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) H W Laycock, M. D.
Oct 8, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Oct 11 1930

20. Undertaker R B Mooney Address Coeur d'Alene

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72433

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 126

(No. Lakeside Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME Clarence Lee Cross

(a) Residence. No. Harrison, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 23, 1925

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
5	0	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS

10. NAME OF FATHER Perry Cross

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Clara Dimica

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Perry Cross
(Address) Harrison, Idaho.

15. Filed 9/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 10, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1930, to Sept 10, 1930
that I last saw him alive on Sept. 10, 1930
and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:
Acute intestinal Obstruction following operation for ruptured appendix
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis Ruptured appendix
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?

Did two operation precede death? yes Date of Sept. 6 Sept 10

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) E R Spohn, M. D.

Sept 11, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harrison, Ida.
Date of Burial 19

20. Undertaker: R. B. Mooney
Address: Coeur d'Alene, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72434

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 127

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME W. H. Harris

(a) Residence. No. 719 A St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Florence Harris

6. DATE OF BIRTH (month, day and year) April 28th 1866

7. AGE Years 64 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sawyer
(b) General nature of industry, business, or establishment in which employed (or employer) Western Pine Co.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bath. N. Y.

PARENTS

10. NAME OF FATHER Hiram Roger Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Elmira New York
12. MAIDEN NAME OF MOTHER Susan Ingersall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New Jersey

14. Informant W H Harris Jr.
(Address) 719 A St. Coeur D'Alene.

15. Filed 9/29/30, 19.... H J Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to to Sept 15, 1930
that I last saw him alive on Sept. 15, 1930
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows: Causer of bladder

(duration) 4 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Wellington Dawes M. D.
Sept. 17, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. C D Alene — Date of Burial 9-17 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72435

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 128

88a

2. FULL NAME Herman A. Tucker

(a) Residence. No. Coeur d'Alene Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Hazel Tyree Tucker

6. DATE OF BIRTH (month, day and year) 1881 9-

7. AGE Years 49 Months 0 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Geo. Tucker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Ella
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Jean Tyree
(Address) 202 So 7th St

15. Filed 9/29, 1930. H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 15th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 15, 1930
that I last saw him alive on Sept 15, 1930
and that death occurred, on the date stated above, at 11:00 A. m.
The CAUSE OF DEATH* was as follows:
Endocarditis acute
(With possible emboli)
(H. A. Tucker fell dead on street)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinical signs
(Signed) E. L. Spohn, M. D.
Sept 17, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Greenwood Wardner. Idaho — Date of Burial 9-18 1930

20. Undertaker Cassedy Funeral Home — Address C D Alene Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72436

Local Registrar's No. 129

164

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Patrick Lundy

(a) Residence. No. 421 Coeur D' Alene Ave. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 15, 1842

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	10	5	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Anthony Lundy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margeret Sweeney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Winifred Lundy

(Address) Coeur D' Alene, Idaho

15. Filed 9/29, 1930, N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to ....., 19....., that I last saw him alive on Sept 11, 1930 and that death occurred, on the date stated above, at 11:45 A m.

The CAUSE OF DEATH* was as follows:-

Old age

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. D. Myers, M. D.

Sept 22, 1930 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Thomas Cemetery	9/22 1930

20. Undertaker R B Mooney Address Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72437

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 130
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Morrison

(a) Residence. No. ..... St. Spokane, Wn. 181
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 17 1904

7. AGE: Years 26, Months 3, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Chester Wash.

PARENTS

10. NAME OF FATHER: Malcolm Morrison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ontario Canada
12. MAIDEN NAME OF MOTHER: Johanna Mc Donald
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nova Scotia Canada.

14. Informant: Malcolm Morrison
(Address) E2707 - 4th Ave., Spokane, Wash.

15. Filed 9/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12 P m.
The CAUSE OF DEATH* was as follows: Gas Fumes from painting interior of Water Tank
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. H. Young Evans M. D.
Sept 19, 1930 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane, Wn.
Date of Burial: Sept 22 1930

20. Undertaker: Turnbull and Co
Address: Spokane Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72438

PLACE OF DEATH
County of Koolenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 131

177

2. FULL NAME Wilma Fay Brown
(a) Residence. No. 1025 - 3rd St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1929 6 - 27
7. AGE Years 1 Months 3 Days 2 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Coeur d'Alene Ida.

PARENTS
10. NAME OF FATHER Claude Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Staples Minn.
12. MAIDEN NAME OF MOTHER Ethel Jorgenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Spokane, Wn.

14. Informant Claude Brown
(Address)
15. Filed 9/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 29 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930 to Sept 29, 1930
that I last saw her alive on Sept 29, 1930
and that death occurred, on the date stated above, at 10 30 P. m.
The CAUSE OF DEATH* was as follows:
Unknown Possible accidental poisoning
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Gastro enteritis with Convulsions
10 hrs duration (duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) E. L. Spohn, M. D.
Oct 1, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. CD Alene
Date of Burial 10-1 1930
20. Undertaker Cassedy Funeral Home
Address CD Alene

Ada Wood

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72439

PLACE OF DEATH
County of Kootenai
City of Coeur D' Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 132
(No.) 19 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles E. Gridley

(a) Residence. No. 802 South Eleventh St.
(Usual place of abode)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Nettie Gridley

6. DATE OF BIRTH (month, day and year): Jan. 7, 1857

7. AGE

Years	Months	Days	If LESS than 1 day,
73	9	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Flint, Mich.

PARENTS

10. NAME OF FATHER: John Gridley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York
12. MAIDEN NAME OF MOTHER: Sarah Rouse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Y.

14. Informant: A. L. gridley
(Address) Coeur D' Alene, Idaho

15. Filed 9/29, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 25, (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from April, 1930, to Sep. 25, 1930
that I last saw him alive on Sep. 25, 1930
and that death occurred, on the date stated above, at 11 a m.
The CAUSE OF DEATH* was as follows:
Chronic myocardial degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual.
(Signed) John Gilland, M. D.
Sep. 26, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	9/27/30 19

20. Undertaker: R. B. Mooney
Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72440

PLACE OF DEATH
County of Kootenai
City of

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 133

205-B

2. FULL NAME Carroll Robison
(a) Residence. No. Lane Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) unknown

7. AGE: Last Years 79 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS

10. NAME OF FATHER: unknown Robison
11. BIRTHPLACE OF FATHER (city or town) (State or Country): U S
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): U S

14. Informant: Mrs Minnie Eaton
(Address) 581 E 57th North, Portland Ore

15. Filed 9/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: (unknown) Had been dead several days when body was found, (death due to natural causes) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Had not been in good health for some time (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. B. Mooney Coroner, M. D.
Sept 30, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery | Date of Burial: Sept 30 1930

20. Undertaker: R. B. Mooney | Address: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72441

Local Registrar's No. 134

2. FULL NAME John Walter Jones always called Jack Jones. 48 B

(a) Residence. No. 1401 - 6th St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE Black

5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Winnie Jones.

6. DATE OF BIRTH (month, day and year) 1850 - 8 - 7

7. AGE Years 80 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired soldier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nashville Tenn.

PARENTS

10. NAME OF FATHER Geo. Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country) West India

12. MAIDEN NAME OF MOTHER Dont-Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont-Know.

14. Informant
(Address) Winnie Jones

15. Filed 9/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 29. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Sept. 29, 1930

that I last saw him alive on Sept 29, 1930

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? His home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Signs

(Signed) E. L. Spohn, M. D.

Oct. 1, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. CD Alene — Date of Burial 10-1 1930

20. Undertaker Cassedy Funeral Home — Address CD Alene

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72412

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No.
Primary Registration District No.
Local Registrar's No. 135
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME John C. Linn

(a) Residence. No. 932 - 6th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Emma Linn

6. DATE OF BIRTH (month, day and year) 1861-2-12

7. AGE	Years	Months	Days	If LESS than 1 day,
	68	7	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS
10. NAME OF FATHER Don't know Linn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Don't Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Emma Linn
(Address)

15. Filed 9/29, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930 to Sept 22, 1930
that I last saw him alive on Sept 22, 1930
and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Glomerulonephritis, chronic
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Cardiac decompensation
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Do not know
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Harold T. Anderson, M. D.
Sept 26, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal	Date of Burial
Forest Cem. C'Alene	9-26 1930
20. Undertaker	Address
Cassedy Funeral Home	C'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72443

PLACE OF DEATH
County of Kootenai
City of .....

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 136

1899

2. FULL NAME Benjamin H Miles
(a) Residence. No. ..... St. Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): unknown

7. AGE: Years 42 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Timber Worker
(b) General nature of industry, business, or establishment in which employed (or employer): Log Loader
(c) Name of employer: A. B. Colburg

9. BIRTHPLACE (city or town) (State or country): Wis

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

Unknown

14. Informant: A. B. Colburg
(Address) 718 E 2nd ave Spokane, Wn.

15. Filed 11/10, 1930 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 12:15 P m.
The CAUSE OF DEATH* was as follows:
Skull Crushed (Struck by Log accidental)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) [illegible] Coroner, M. D.
Oct 7th, 1930 (Address) Pound Alene Wa

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery | Date of Burial: Oct 8 1930

20. Undertaker: Mooney Mortuary | Address: Pound Alene

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72441

PLACE OF DEATH

County of Kootenai

City of .....

Registration District No. 3a

Primary Registration District No. 1050

Local Registrar's No. 137

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Buckle Sr.

(a) Residence. No. Hayden Lake, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Buckle

6. DATE OF BIRTH (month, day and year) April 3, 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	6	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Anthony Buckle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Dastyler

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Joseph Buckle Jr.

(Address) Hayden Lake Idaho

15. Filed 11/10, 1930 W. J. Sturges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to Oct. 5, 1930
that I last saw h— alive on Oct. 4, 1930
and that death occurred, on the date stated above, at 2300 9 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
6 hrs
(duration) — yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) General Atheroma
about 6
(duration) — yrs. mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) Frank (illegible), M. D.
10/7, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cemetery	Oct 7 1930
20. Undertaker	Address
R B Mooney	Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

2

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72445

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 135

PLACE OF DEATH
County of Kootenai
City of Rathdrum
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Gustave Roth

(a) Residence. No. Twin Lakes St.
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Roth

6. DATE OF BIRTH (month, day and year) March 30-1852

7. AGE	Years	Months	Days	If LESS than 1 day,
	77	6	3	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lima Oll.

PARENTS

10. NAME OF FATHER Conrade Roth
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Minnie Eichler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany.

14. Informant Walter Hannahs
(Address) Rathdrum Idaho

15. Filed 11/10, 1930 N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29, 1930, to Oct. 3, 1930
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 10:45 p.m.

The CAUSE OF DEATH* was as follows:
Valvular Heart + Kidneys
(mitral Stenosis)
about 2 (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Nephritis
about 1 (duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Frank Henry, M. D.
10/4, 1930 (Address) Rathdrum, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cem. Co. Rathdrum	10-6 1930
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72446

PLACE OF DEATH

County of Koot
City of C.d'A.

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 139

74C

2. FULL NAME Alice Harreld

(a) Residence. No. - 12th & Montana St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of J.H. Harreld

6. DATE OF BIRTH (month, day and year) June 21 1873

7. AGE: 57 Years: 57 Months: 4 Days: 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ——
(c) Name of employer: ——

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Donald Fulk.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind
12. MAIDEN NAME OF MOTHER: Sarah ——
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind.

14. Informant: J.H. Harreld
(Address) C.d.A.

15. Filed 11/10, 1930 H. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-30-, 1930, to 10-30-, 1930
that I last saw her alive on did not see alive 19..
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) 10-31 E.H. Reed, M. D.
10-31-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery
Date of Burial: Nov. 2 1930

20. Undertaker: R. B. Mooney
Address: C.d.A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REGISTERED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72447

Local Registrar's No. 140

PLACE OF DEATH

County of Koot

City of Cd'A.

Registration District No. 30

Primary Registration District No. 3050

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Weaver 90

(a) Residence. No. 1040 Young St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. (If married, widowed, or divorced) HUSBAND of ~~(or) WIFE of~~ Emily Weaver

6. DATE OF BIRTH (month, day and year) 1852 - aug 18

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
78	78	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): ~~Ohio~~ Illinois

PARENTS

10. NAME OF FATHER: George Weaver
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: alice Ross
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs Emily Weaver
(Address): C.d.A.

15. Filed 11/10, 1930 W. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Oct 30, 1930
that I last saw h— alive on Oct 30, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:
Arteriole Sclerosis

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. 2 mos. 15 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Reed, M. D.
10-31, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	11/1 1930
20. Undertaker: O. D. Mooney	Address: C.d.A.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72448

PLACE OF DEATH
County of Kootenai
City of Post Falls
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 141
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Davis

(a) Residence. No. Post Falls, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nona Davis

6. DATE OF BIRTH (month, day and year) May 10, 1891

7. AGE: Years 39 | Months 5 | Days 18 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Maple N. Carolina

PARENTS

10. NAME OF FATHER: W. P. Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.
12. MAIDEN NAME OF MOTHER: Ellen Issacs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. Carolina

14. Informant: Mrs Nona Davis,
(Address): Post Falls, Ida.

15. Filed 11/10, 1930 N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 28, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Hemorrage due to Pulmonary Tuberculosis
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? in army
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) L. L. McFarlin M. D.
Oct 30, 1930 (Address) Post Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasent View Cem. | Date of Burial: Oct 30 1930

20. Undertaker: G. B. Mooney Address: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 15 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootnei

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1050

(No. , St.)

File No. 72449

Registered No. 142

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Divorced (Write the word.)

6. DATE OF BIRTH. March (Month) 21 (Day) 1860 (Year)

7. AGE 70 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur M. Pedersen

(Address) Portland, Oregon

15. Filed 11/10 1930 H. J. Sturges Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 90

Oct (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1930, to Aug 17 1930, that I last saw him alive on Aug 17 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Organic heart lesion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. Clanton M. D.

..... 19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 11 yrs. ..... mos. ..... days. In the State 11 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Washington

DATE OF BURIAL: Oct 21 1930

20. UNDERTAKER: Hazen & Jaeger

ADDRESS: Spokane, Wash

SYMS - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72450

PLACE OF DEATH
County of Kootenai
City of Post Falls

Registration District No. 30
Primary Registration District No. 1650
Local Registrar's No. 143

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jay O'Fallon

(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1918 - 12 - 26

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10. NAME OF FATHER Jay O'Fallon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wyoming.
12. MAIDEN NAME OF MOTHER Ruth May Haines
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden. Utah

14. Informant J. O'Fallon
(Address) Post Falls, Ida

15. Filed 11/10, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 2. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 2 1930, to November 2 1930
that I last saw him dead on November 2, 1930
and that death occurred, on the date stated above, at 4.00 P.m.
The CAUSE OF DEATH* was as follows:
Accidental traumatism
Automobille accident.
Skull fracture
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? McGuires Corner Idaho.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs
(Signed) E. L. Sparks M. D.
Nov. 4, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasant View Cem. Ida. | Date of Burial: 11-4 1930

20. Undertaker: Corsedy Funeral Home | Address: CDalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72451

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 144

PLACE OF DEATH
County of Kootenai
City of Post Falls.
(No.) 48 B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles E. Oakes

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1848 - 2 - 18

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	7	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER Geo. W. Oakes
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Catherine McGinnis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant
(Address)

15. Filed 11/10, 1930 N. J. Stevens Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1930 to Oct 9, 1930
that I last saw h. in alive on Oct 3, 1930
and that death occurred, on the date stated above, at 9 45 9. m.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) Not known yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. O. Myers M. D.
Oct 7, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Park, Spokane	10 - 1930
20. Undertaker	Address
Hagen & Jaeger	Spokane Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72452

Registration District No. 30
Primary Registration District No. 1030
Local Registrar's No. 153

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

74a

PLACE OF DEATH
County of Kootenai
City of Rathdrum

2. **FULL NAME** John Heitman

(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Heitman

6. DATE OF BIRTH (month, day and year) February 3 1841

7. AGE	Years	Months	Days	If LESS than 1 day,
	89	7	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired-Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Claremont
(State or country) Penn.

PARENTS

10. NAME OF FATHER Francis Heitman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mary
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Lily H. Heitman
(Address) Acme Alberta

15. Filed 11/10, 1930 N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 19. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1930, to Sept. 19, 1930
that I last saw h[illegible] alive on Sept. 18, 1930
and that death occurred, on the date stated above, at 5.15 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) Old Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Dr
(Signed) Frank Mann, M. D.
9/20, 1930 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery Coeur d'Alene	9/21 1930
20. Undertaker	Address
Cassedy Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72453

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 145

4613

2. FULL NAME Ada V. Cook

(a) Residence. No. 328 N. 16th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Melford Cook

6. DATE OF BIRTH (month, day and year) 1856 - 7 - 31

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	2	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know.

14. Informant Mrs Elizabeth Davis
(Address) Coeur d Alene Idaho.

15. Filed 11/10, 1930 N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1928, to Oct. 24, 1930
that I last saw her alive on Oct. 20, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturgess, M. D.
Oct. 31, 1930 (Address) Coda Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C'Dalene	10-25-1930
20. Undertaker	Address
Cassedy Funeral Home	C'Dalene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72454

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 146

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Max Hossfeld

(a) Residence. No. Appt. Over Great Northern Depot. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Essie V. Hossfeld

6. DATE OF BIRTH (month, day and year): 1882 June 7th

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	3	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Agent, Great Northern

(b) General nature of industry, business, or establishment in which employed (or employer): Railway.

(c) Name of employer: G. N. Railway

9. BIRTHPLACE (city or town) (State or country): Minn.

PARENTS

10. NAME OF FATHER: Max Hossefeld Sr.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Johana Schmeidt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. Essie V. Hossfeld
(Address) Coeur D' Alene, Idaho.

15. Filed 11/10, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 5, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 24, 1930, to Oct. 3, 1930

that I last saw him alive on Oct. 3, 1930

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary): Influenza.

(duration) ..... yrs. ..... mos. 14 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual.

(Signed) John Wood, M. D.

Oct. 6, 1930 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Forest Cemetery

Date of Burial: 10/6/30 19

20. Undertaker: R. B. Mooney

Address: Coeur d'Alene

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72455

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No.)
Local Registrar's No. 147

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary E. Lindley

(a) Residence. No. 303 Garden St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Gardner W. Lindley

6. DATE OF BIRTH (month, day and year) 1866 - 1 - 9

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	9	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hillsdale Co. Mich.

PARENTS

10. NAME OF FATHER LaFayette Sherman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Lottie Welker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Harold S. Lindley
(Address)

15. Filed 11/10, 1930 N. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30, 1930, to Oct 30, 1930
that I last saw her alive on Oct 29 1930
and that death occurred, on the date stated above, at 6 50 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. H. Deal M. D.
10-31-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CD Alene	11-2 1930
20. Undertaker Cusack Funeral Home	Address CD Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72456

Local Registrar's No. 146

PLACE OF DEATH

County of Kootenai

City of Post Falls

Registration District No. 3e

Primary Registration District No. 1007

(No. 201)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth McHenry

(a) Residence. No. Post Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac McHenry Deceased

6. DATE OF BIRTH (month, day and year) Jan. 15, 1841

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	89	9	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Soloman Hand

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary Pearson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ill.

14. Informant Mrs. Kate Collins

(Address) Sand Point, Idaho

15. Filed 11/10, 193[illegible] N. J. Sturgen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1930, to Oct 22, 1930, that I last saw her alive on Oct 22, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Shock following
Fracture of Femur

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. McCauley M. D.

Oct 24 1930 (Address) Post Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls Cemetery	10-25 1930
20. Undertaker	Address
W. L. D. Mooney	Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPA

State File No. 72457

Registration District No. 30

Primary Registration District No. 1000

Local Registrar's No. 149

(No.) Cougar Gulch (If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH

County of Kootenai

City of

2. FULL NAME Louis Peterson

(a) Residence. No. Spokane, Wn. St. Spokane, Wn.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE — Years: 64 — Months: — Days: — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Andrew Leiman

(Address) Coeur D' Alene, Ida. Route #I

15. Filed 11/10, 1930 W. J. Stinger Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Natural Causes) Unknown
found dead in bed, had
not been well for 1 yr

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Investigation

(Signed) R B Mooney M. D.

Oct 23, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Oct 24 1930
20. Undertaker	Address
R B Mooney	Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

RECEIVED NOV 15 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Worley, Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1050

(No. ..... , ... St.)

File No. 72458

Registered No. 750

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sadie McWilliam

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married, (Write the word.)

6. DATE OF BIRTH: April (Month) 15 (Day) 1879 (Year)

7. AGE: 51 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sales Lady

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): McMinnville Oregon

10. NAME OF FATHER: M. V. Gortner

11. BIRTHPLACE OF FATHER (State or Country): Pensylvania

12. MAIDEN NAME OF MOTHER: Ellen Webster

13. BIRTHPLACE OF MOTHER (State or Country): Pensylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. R. McWilliam

(Address) Worley, Ida.

15. Filed 11/10 1930 H. J. Sturges Local Registrar

MEDICAL CERTIFICATE OF DEATH

47

16. DATE OF DEATH: Oct (Month) 12th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4th 1930, to Oct 12th 1930, that I last saw her alive on Oct 12th 1930, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Cancer of Breasts and Liver

(Duration) 2 Yrs. 6 mos. ..... ds.

Contributory (Secondary) General Debility.

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. J. Herrington M. D.

19..... (Address) Worley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McMinnville, Ore

DATE OF BURIAL: Oct 16 1930

20. UNDERTAKER: H. L. Jaeger

ADDRESS: Plummer Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72459

PLACE OF DEATH
County of Koolenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 151

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie Varnum. 70

(a) Residence. No. 1021 - 1st. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Ernest-Varnum

6. DATE OF BIRTH (month, day and year) 1864-9-8

7. AGE Years 66 Months 2 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine

PARENTS
10. NAME OF FATHER --- Elsmore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont-Know.
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. Elsie Prosser
(Address) 820 St. Maries.

15. Filed 11/10, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1927, 19..., to Nov. 11, 1930
that I last saw her alive on Nov. 6, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows: Encephalitis Lethargica.

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? History & absence of other sets
(Signed) John Elwood, M. D.
Nov. 13, 1930 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest-Cem. CD Alene — Date of Burial 11-13 1930

20. Undertaker Cassedy Funeral Home — Address CD Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72460

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 152

(No. Coeur D' Alene Home for the Aged)
(If death occurred in a hospital or institution, give its name instead of street and number.)

140

2. FULL NAME Lambert R. Willard

(a) Residence. No. (Usual place of abode) St. Spokane, Wn. (If nonresident give city or town and State)

Length of residence in city or town where death occurred. I yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 30, 1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	2	6	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Simon Willard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Sarah Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Office of The C. D' A. Homes,
(Address) Coeur D' Alene, Idaho.

15. Filed 11/10, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 6, 1930

that I last saw him alive on Oct 31, 1930

and that death occurred, on the date stated above, at 1 1 m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral Hemorrhage)

(duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis. Hypertension

(duration) Not known yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Mooney, M. D.

Nov 10, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	Nov. 10 1930
20. Undertaker	Address
R. B. Mooney	Coeur d'Alene,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72461

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 154

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Sam. Sweet
(a) Residence. No. County Hospital St. Lane Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) July 17 – 1855
7. AGE Years 75 Months 2 Days 8 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Do not know
PARENTS
10. NAME OF FATHER " " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) "
12. MAIDEN NAME OF MOTHER " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "
14. Informant Mrs. Helen Brown
(Address) Matron County Hospital
15. Filed 11/10, 1930 H J Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 25 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Septbr. 24, 1930, to Septbr. 25, 1930
that I last saw him alive on Septbr. 24, 1930
and that death occurred, on the date stated above, at 7.45 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Old age
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? ?
(Signed) Frank Wenz, M. D.
9/25, 1930. (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pine Grove Cemetery Rathdrum
Date of Burial: 9/28 1930
20. Undertaker: Cassedy Funeral Home
Address: Rathdrum

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72462

PLACE OF DEATH
County of Kootenai
City of Rathdrum

Registration District No. 35
Primary Registration District No. 1053

Local Registrar's No. 155

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

H5

2. FULL NAME Ann Eliza Wilson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. F. Wilson Dec.

6. DATE OF BIRTH (month, day and year) May 13—1845

7. AGE Years 85 Months 4 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Stephan Adams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Matilda Walker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ——

14. Informant Ida May Adams
(Address) Rathdrum Idaho

15. Filed 11/13, 1930 A. J. Stringer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to Sep. 13, 1930
that I last saw her alive on Sep. 12, 1930
and that death occurred, on the date stated above, at 5:40 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma small intestines

..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Old age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Frank Wang, M. D.
9/14, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery Rathdrum	9/16 1930
20. Undertaker	Address
Conkey Funeral Home	Rathdrum

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25-M-1-19

RECEIVED NOV 15 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1050.
File No. 72463
Registered No. 132

1. PLACE OF DEATH

County of Kootenai
City of Hooley. Ida.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louvier J Bailey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May 14th 1861.
(Month) (Day) (Year)

7. AGE: 69 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Proprietor "Retired"
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Joe. Missouri

10. NAME OF FATHER: Geo Bailey

11. BIRTHPLACE OF FATHER (State or Country): Portland Me.

12. MAIDEN NAME OF MOTHER: Abbey.

13. BIRTHPLACE OF MOTHER (State or Country): Portland, Me.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie F Bailey
(Address) 509-32nd St Ernest Idaho

15. Filed Nov 10 1930
N. J. Sturges
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 8th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7th 1930, to Oct 8th - 1930, that I last saw him alive on Oct 8th - 1930, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Haemoptysis
48 hours.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) T.B.
Cant Say. (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Kissington M. D.
10/6 1930 (Address) Hooley. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ernest, Ida. | DATE OF BURIAL: 10/13/30

20. UNDERTAKER: [signature] | ADDRESS: Plummer

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED NOV 12 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72464
Local Registrar's No.

1. PLACE OF DEATH
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 63
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Terry Yancie Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	married

6. DATE OF BIRTH: October (Month) 12 (Day) 1859 (Year)

7. AGE: 70 Yrs. 10 Mos. 29 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dallas Texas

10. NAME OF Father: David Ellis

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Lucy Woodard

13. BIRTHPLACE OF MOTHER (State or Country): Tex

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Ellis
(Address): Kendrick

15. Filed Sept 12 1930 B. P. Watt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1929. to Sept 11 1930, that I last saw him alive on Sept 10 1930, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. 8 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. H. Tuell M. D.
Sept 11 1930. (Address) Kendrick Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick — DATE OF BURIAL: 9/12 1930

20. UNDERTAKER: John Pickard — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72465

Registration District No. 63
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Oneida
City of Juliaetta
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Warren C. Grosscloss
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27-1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	2	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J. J. Grosscloss

9. BIRTHPLACE (city or town) Beaudo. (State or country) Virginia

PARENTS

10. NAME OF FATHER J. J. Grosscloss
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Sarah Kimbeling
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Mrs. J. J. Grosscloss
(Address) Juliaetta, Idaho

15. Filed Sept 29, 1930 B. F. Hart Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1930, to Sept. 27, 1930
that I last saw h[illegible] alive on Sept. 26, 1930
and that death occurred, on the date stated above, at 4-a.m.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis several years.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? There. Juliaetta
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical + t.b. sputum
(Signed) E. H. Field, M. D.
Sept 25, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Juliaetta	Sept 28 1930
20. Undertaker	Address
John Pickard	Troy, Ida.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72466

Registration District No. 63
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

PLACE OF DEATH
County of Latah
City of Kendrick

2. FULL NAME Mary Fraser

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of David Prescott Fraser

6. DATE OF BIRTH (month, day and year) Jan 16 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER Benjamin Kees
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Martha Prescott
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vermont

14. Informant David Fraser
(Address) Kendrick Idaho

15. Filed Sept 28, 1930 B. F. Mark, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1930, to Sept. 27, 1930, that I last saw her alive on Sept. 26, 1930 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:
Heart failure
Chronic Myocarditis
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Chas. A. Meyer, M.D.
Sept. 28, 1930 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wildwood Cemetery	Sept. 29 1930
20. Undertaker John F. Pickard	Address Troy Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72467

PLACE OF DEATH
County of Lutah
City of Juliaetta

Registration District No. 63
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Joseph C Groseclose

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Laura Groseclose

6. DATE OF BIRTH (month, day and year) Dec 31st 1867

7. AGE Years 62 Months 8 Days 26 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS
10. NAME OF FATHER Joseph Groseclose
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Elizabeth Crabtree
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Laura Groseclose
(Address) Juliette Ida.

15. Filed Sept 29, 1930 B. F. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 27, 1930
that I last saw him alive on Sept 26, 1930
and that death occurred, on the date stated above, at 10 p. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. H. Field, M. D.
Sept 27, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Juliaetta
Date of Burial Sept 30 1930

20. Undertaker J. J. Pickerd
Address Troy, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72468

PLACE OF DEATH
County of Lavale
City of Juliaetta
Registration District No. 63
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geo. W. Guthrie 90

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single
6. DATE OF BIRTH (month, day and year) May 2, 1863
7. AGE — Years 67 — Months 4 — Days 29 — If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS
10. NAME OF FATHER William Guthrie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Mary Jane Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant W. J. Guthrie
(Address) Juliaetta, Ida.
15. Filed Oct 4, 1930 B. H. Nesbit Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 24, 1930, to Oct. 1, 1930
that I last saw him alive on Oct. 1, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Aortic Stenosis
Arteriosclerosis
Unknown (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Jaundice
(duration) yrs. mos. 2 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinically
(Signed) E. H. Field, M. D.
Oct. 1, 1930 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Juliaetta — Date of Burial Oct 4 1930
20. Undertaker J. J. Pickard — Address Troy, Ida.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72469

PLACE OF DEATH
County of Nez Perce
City of Leland Idaho

Registration District No. 63
Primary Registration District No.
(No.)
Local Registrar's No. 1610

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas C. Cook

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 7 - 1858

7. AGE: Years 71 | Months 11 | Days 13 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Cook
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland.

14. Informant: Mrs. T. C. Cook
(Address): Leland, Idaho

15. Filed Oct 20 1930 B. F. Corbet
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14th, 1930, to Oct 20th, 1930, that I last saw him alive on Oct 20th, 1930, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Complications of Old age (duration) 1 yrs. 1 mos. 1 ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Clinical tests

(Signed) Russell Jewett M. D.
Oct 20th, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Leland, Idaho — Date of Burial: 10/22 1930

20. Undertaker: Brower-Ware Co — Address: Lewiston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72470

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Deary
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Hokan Renstrom

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not Married

6. DATE OF BIRTH (month, day and year) Nov-2-1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Hokan Renstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Wm Burklund
(Address) Deary Ida

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1930, to Nov. 2, 1930
that I last saw him alive on Nov. 31, 1930
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M.D.
, 19 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72471

NOV 15 1930

PLACE OF DEATH
County of Lemhi
City of Baker

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cora M. Kuhn
(a) Residence. No. Baker Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Kuhn

6. DATE OF BIRTH (month, day and year) March 10th 1885

7. AGE Years 1 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER James McGill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Katherine Ferguson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Albert Kuhn Baker Idaho

15. Filed Nov 10, 1930 Cho Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 3rd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Nov 1, 1930
that I last saw her alive on Nov 1, 1930
and that death occurred, on the date stated above, at 12 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of liver

About 1 year (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? clinical
(Signed) Chas F Hammer, M. D.
Nov 3, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal Idaho Falls Cemetery
Date of Burial 19

20. Undertaker Mrs C Daehler
Address Salmon Idaho.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED NOV 15 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Carmen

Registration District No. 41

Primary Registration District No. 2116

(No. ..... St.)

File No. 72472

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evon Maxine Sharp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. 10 (Month) — 18 (Day) 1930 (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Romanzo Sharp

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Jennie E. Jones

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Nutt

(Address) Carmen Idaho

15.

Filed Nov 10 1930 Chas Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH 1610

16. DATE OF DEATH 10 (Month) — 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1930, to ..... 191..., that I last saw her alive on Oct 18 1930 and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Premature
Seventh month

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Stratton M. D.

10/25 1930 (Address) Salmon, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gibbonsville, Ida

DATE OF BURIAL Oct 26 1930

20. UNDERTAKER Clarence Nutt

ADDRESS Carmen Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72473

PLACE OF DEATH

County of Lemhi
City of Salmon

CERTIFICATE OF DEATH

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME George G. Miller

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 12 mos. 6 ds. 15 How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 67 Years | Months: 10 | Days: 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Champaign Ills.

PARENTS

10. NAME OF FATHER: John Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Cincinnati Ohio
12. MAIDEN NAME OF MOTHER: Harvey
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Carthage Mo.

14. Informant (Address): B. F. Miller Alqva Texas

15. Filed Nov 10, 1930 Clio Billamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 24th (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1930, to Oct 23, 1930
that I last saw him alive on Oct 23, 1930
and that death occurred, on the date stated above, at 4-30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) Probably 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) T. S. Wright, M. D.
Oct 28, 1930 (Address) Salmon Ida

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: Oct 26 1930

20. Undertaker: Wm. C. Doebler | Address: Salmon Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72474

RECEIVED NOV 7 1930

PLACE OF DEATH

County of Lemhi

City of Leadore

Registration District No. 41

Primary Registration District No. 2116 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mathew Rooney

(a) Residence. No. ..... Leadore St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Quarty Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER John Rooney

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Ridge Ginnn

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Dan Rooney Gilmore Idaho

15. Filed Nov. 10, 1930 Chas Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 23 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930 to Oct. 23, 1930
that I last saw him alive on Oct. 23, 1930
and that death occurred, on the date stated above, at 8 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric Ulcers &

Myocardiac failure (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John L. Parker M. D.

Oct 24, 1930 (Address) Leadore

19. Place of Burial, Cremation, or Removal Junction Cemetery — Date of Burial Oct 25 1930

20. Undertaker J. M. C. Nebb — Address Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72475

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME —
(a) Residence. No. Salmon Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) —
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) September 26 - 30
7. AGE Years — Months less Days 1 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —
9. BIRTHPLACE (city or town) (State or country) Salmon Idaho
PARENTS
10. NAME OF FATHER Andrew Van Den Berg
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)
14. Informant (Address) Andrew [illegible]
15. Filed Nov 10, 1930 Clio Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 26th (Month) (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Sept 26, 1930
that I last saw h..... alive on Sept 26 1930
and that death occurred, on the date stated above, at 8 a m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Blue baby lived 12 hours.
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) F. S. Wright, M. D.
Oct 15, 1930 (Address) Salmon
19. Place of Burial, Cremation, or Removal Salmon Cemetery Date of Burial 9/27" 1930
20. Undertaker Wm C. Doebler Address Salmon Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72476

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME R Owen Swift 91B
(a) Residence. No. Salmon Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Swift.
6. DATE OF BIRTH (month, day and year) Jan. 1882
7. AGE 48 Years Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Hailey Idaho

PARENTS
10. NAME OF FATHER James Owen Swift.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or County) —

14. Informant (Address) Olive Swift - Wife. Salmon Idaho
15. Filed Nov 10, 1930 Clio Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 26th, 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to Sept 26, 1930
that I last saw him alive on Sept 25, 1930
and that death occurred, on the date stated above, at 4 a m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arterial Hypertension
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? History of Case
(Signed) T J Knight, M. D.
Oct 16, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 9/28" 1930
20. Undertaker Wm C Hockler
Address Salmon Idaho

RECEIVED NOV 15 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72477

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Cowan
(a) Residence. No. Salmon Idaho St. 90
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE Years about 56 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Died at County Farm
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) American

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) Wm C Toebler Salmon Ida.

15. Filed Nov 10, 1930 Chas Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 20th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15, 1930, to Sept 19, 1930
that I last saw him alive on Sept 19, 1930
and that death occurred, on the date stated above, at 9 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

acute [illegible]
Several [illegible] (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Oct 23, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal Salmon Cemetery | Date of Burial 9/21st 1930

20. Undertaker Wm C Toebler | Address Salmon Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-A 25 M. 1-30

RECEIVED NOV 15 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 72478
Registered No. .....

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace Tonkray Albertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: September 14. (Month) (Day) 1860 (Year)

7. AGE: 69 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Issaac Albertson

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Eugenia Tonkray

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie Albertson
(Address) Baker, Idaho.

15. Filed Nov 10 1930 Chas Bellamy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 12 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to Sept 12 1930
that I last saw him alive on Sept 11 1930
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ? Yrs. ? mos. ? ds.
Contributory (Secondary) Hypertension
(Duration) ? yrs. ? mos. ? ds.

(Signed) F. S. Wright M. D.
9/19 1930 (Address) Salmon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 9/14/1930
20. UNDERTAKER: W. C. Hoelle — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED OCT 25 1930
RECEIVED JUL 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72479

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No.)
Local Registrar's No. 4

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl B Austin

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ona May

6. DATE OF BIRTH (month, day and year) April 2, 1899

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	3	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kooskia Ida.

PARENTS

10. NAME OF FATHER C. C. Austin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Austin
13. BIRTHPLACE OF MOTHER (city or town) Linn Co Mo (State or Country)

14. Informant Frank Edwards
(Address) Kamiah Idaho

15. Filed 7-7-30 H. W. Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5th 1930, to July 6th, 1930
that I last saw h[illegible] alive on July 6th, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

about 24 hrs.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of Brain

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C. B. Bryan, M. D.
July 6th 1930 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Kam	7-9 1930
20. Undertaker	Address
Kamiah Funeral Home	Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72480

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
Local Registrar's No. 24

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME E. V. Wilson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Carrie Wilson

6. DATE OF BIRTH (month, day and year) Apr-5-1858

7. AGE Years 72 Months 1 Days 29 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mineral City Ohio

PARENTS
10. NAME OF FATHER P. D. Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. Wade Wilson
(Address) Kamiah Idaho

15. Filed 7/15, 1930 W. Hoheim Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th, 1930, to June 4th, 1930
that I last saw him alive on 6/4th, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Myocarditis

..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Influenza

..... (duration) ..... yrs. ..... mos. 7 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [signature], M. D.
6/5th 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah
Date of Burial 6/6/1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72481

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2129
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

129

2. FULL NAME Parker Pierce

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1848

7. AGE 81 Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant F H Ribbey
(Address) Kamiah Ida

15. Filed 3/15, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to Above, 19
that I last saw him alive on March 14th, 1930
and that death occurred, on the date stated above, at 12 noon.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
(duration) ? yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremic Coma
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? –
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Tolerance
(Signed) [signature], M. D.
March 15, 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah
Date of Burial 3/16 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72482

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
Local Registrar's No. 27

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

31

2. FULL NAME Leland James Blackeagle

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 8-1929

7. AGE Years 1 Months 3 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS

10. NAME OF FATHER Joseph Blackeagle
11. BIRTHPLACE OF FATHER (city or town) Kamiah
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Ida Corbett
13. BIRTHPLACE OF MOTHER (city or town) Lapwai
(State or Country) Idaho

14. Informant Joseph Blackeagle
(Address)

15. Filed 8/22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1930, to Aug, 1930
that I last saw him alive on Aug. 18th, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Pulmonary T. B.

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) [signature], M. D.
Aug. 23, 1930 (Address) Kamiah Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah
Date of Burial 8/23 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

12482?

1 PLACE OF DEATH
County Lemhi State Idaho Registered No.
Township ____ or Village Ramiah or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James Blackeagle Reid 1-14-31
(a) Residence. No. Ramiah St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	7/8 Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 9. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ramiah
(State or country) Ida.

PARENTS
10 NAME OF FATHER Joseph Blackeagle
11 BIRTHPLACE OF FATHER (city or town) Ramiah
(State or country) Ida.
12 MAIDEN NAME OF MOTHER Ida Corbett
13 BIRTHPLACE OF MOTHER (city or town) Stites
(State or country) Idaho

14 Informant Corbett B. Lawyer-Clerk
(Address) Lapwai Ida

15 Filed Aug 24, 1930 [illegible] Registrar

11—8184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 19[illegible]

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
No physician in attendance

____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) ____, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Ramiah Cemetery	Sept 1 19[illegible]
20 UNDERTAKER	**ADDRESS**
Geo. W. Emery	Moscow

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 96

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72483

PLACE OF DEATH
County of Idaho
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

161a

2. FULL NAME Baby Snyder

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, 7 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kamiah
(State or country)

PARENTS
10. NAME OF FATHER Homer Snyder
11. BIRTHPLACE OF FATHER (city or town) West Va.
(State or Country)
12. MAIDEN NAME OF MOTHER Gallaher
13. BIRTHPLACE OF MOTHER (city or town) Wash.
(State or Country)

14. Informant Homer D Snyder
(Address)

15. Filed Aug 7, 1930 J H Robertson
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 7th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 7, 1930, to Aug 7th, 1930
that I last saw her alive on Aug. 7th, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Premature early
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hart Lesion (Possibly face of Mother)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) [signature], M. D.
Aug. 8, 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grandview
Date of Burial 8/8/1930

20. Undertaker Homer Snyder
Address Kamiah
Acctg.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72484

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

204

2. FULL NAME Edward W Lane

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2-13-1857

7. AGE Years 73 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pool hall operator
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS
10. NAME OF FATHER Thomas Lane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ia.
12. MAIDEN NAME OF MOTHER Martha Sellers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant J W Robertson
(Address) Kamiah

15. Filed 8/27, 1930 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h✓ alive on ....., 19...
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Found dead Heart failure 73 years old (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Albert Huff M.D.
....., 19... (Address) Nezperce Idaho
Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah
Date of Burial Aug 31 1930

20. Undertaker Kamiah Funeral Home
Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72485

PLACE OF DEATH
County of Idaho
City of Woodland

Registration District No. 49
Primary Registration District No. 2129
Local Registrar's No. 23

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Vera Craven

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 9 Years Months 8 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Woodland
(State or country)

PARENTS

10. NAME OF FATHER Levi Craven

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Alta George

13. BIRTHPLACE OF MOTHER (city or town) Kansas
(State or Country)

14. Informant Leva E. Craven
(Address)

15. Filed ....., 19.... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st, 1930, to above, 19....
that I last saw her alive on April 2nd, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Labor Pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) A. S. Byron, M. D.
April 3rd, 1930 (Address) Pleasant

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Woodland Kamiah Funeral Home — Date of Burial 3/ 1 1930

20. Undertaker Kamiah Funeral Home — Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72486

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

2. FULL NAME Henry Adams

90

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 4-6-10

7. AGE 1 Yr 20 | Years 19 | Months 11 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Chas F Adams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Wolf
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisconsin

14. Informant Bertha Adams
(Address) Kamiah Idaho

15. Filed 3/18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1929, to Ahaug, 19..., that I last saw him alive on March 16, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

..... (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rhumatism
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) [signature], M. D.
March 17 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah | Date of Burial 3/18 1930

20. Undertaker Kam Funeral Home | Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72488

PLACE OF DEATH

County of Lewis

City of Winchester

Registration District No. 50

Primary Registration District No. 2129

Local Registrar's No. 18

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Lambert Pekel

(a) Residence. No. Winchester, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 9 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline Pekel

6. DATE OF BIRTH (month, day and year): Oct. 2, 1855

7. AGE: Years 75 | Months | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Milwaukee, Wis.

PARENTS

10. NAME OF FATHER: John Pekel

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Belgium

14. Informant: Mrs Catherine J. Mauk

(Address) Winchester, Idaho

15. Filed 10/15, 1930 R. E. [signature] Registrar

R.E.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930, to Oct. 13, 1930

that I last saw him alive on dead when seen, 1930

and that death occurred, on the date stated above, at 10:30 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Over exercise

..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms only

(Signed) A.B. Halliday, M. D.

Oct. 13, 1930 (Address) Winchester,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. | Date of Burial: 10/15 1930

20. Undertaker: Brower-Wann Company | Address: Lewiston, Idaho

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72489

PLACE OF DEATH
County of Madison
City of Moody Creek

Registration District No. 100
Primary Registration District No. 218
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 56

170

2. FULL NAME Harvy Vaughn

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	38	6	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Sheep herder
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shoshone Idaho

PARENTS

10. NAME OF FATHER: William T. Vaughn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Martha A. McCall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Iowa

14. Informant: Jake Keller
(Address): Sugar City, Idaho

15. Filed 11/4, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Suicide by gun wound through his brain
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Made thorough examination of case.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) F. Schwendiman, M. D.
Nov. 3rd, 1930 (Address) Coroner Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City	11/3 1930
20. Undertaker	**Address**
Russel R. Flamm	Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72490

PLACE OF DEATH

County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 55

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

159e

2. FULL NAME Baby Peterson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~Stillborn~~ Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days If LESS than 1 day, ... hrs. or 20 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ~~Stillborn~~
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Salem
(State or country)

PARENTS

10. NAME OF FATHER Earial Peterson
11. BIRTHPLACE OF FATHER (city or town) Salem
(State or Country)
12. MAIDEN NAME OF MOTHER Mary McMinn
13. BIRTHPLACE OF MOTHER (city or town) Salem
(State or Country)

14. Informant Earial Peterson
(Address) Salem Sugar City P.O.

15. Filed 10/26, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1930, to Oct. 25, 1930
that I last saw her alive on Oct 25, 1930
and that death occurred, on the date stated above, at 11:20 A.m.
The CAUSE OF DEATH* was as follows:
Mal formation of liver
Liver greatly enlarged
Baby lived but 20 min.
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) [signature], M. D.
10-25, 1930 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Rexburg
Date of Burial: 10/27 1930

20. Undertaker: Russell P. Flamm
Address: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT ...

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72491

PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 54
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Elizabeth Lewis

(a) Residence. No. Rexburg St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Evan Lewis

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	66	8	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER James Eckersell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Henrietta McPhail
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Evan Lewis Jr.
(Address) Rexburg Idaho

15. Filed 10/26, 1930 J. Ryan Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 22, 1930
that I last saw her alive on Oct 20, 1930
and that death occurred, on the date stated above, at 8 30 P m.
The CAUSE OF DEATH* was as follows:
Coronary embolism

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Ulcerative Endocarditis
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Lorin L Rich, M. D.
10/25, 1930 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	10/25 1930
20. Undertaker	Address
Russell R. Flamm	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72492

PLACE OF DEATH

County of Madison
City of Archer

Registration District No. 100
Primary Registration District No. 2178

Local Registrar's No. 53

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

122

2. FULL NAME Sarah S. B. Redford

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of: Redford

6. DATE OF BIRTH (month, day and year): April 18th 1859

7. AGE: Years 71, Months 6, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ramsbottom Lancheir England

PARENTS

10. NAME OF FATHER: Samuel Blackburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Sarah S. Lamb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: George Briggs
(Address): Thornton #1

15. Filed 10/23, 1930 J. Nyoming Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September, 1930, to Oct 20, 1930
that I last saw her alive on Oct 20 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows: Cirrhosis of liver (atrophic)
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Arsenitis
..... (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) Lorin I. Rich, M. D.
10/21, 1930 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Sutton Cemetary Archer Ida
Date of Burial: Oct 23 1930.

20. Undertaker: Vern J. Keller
Address: Rexburg

RECEIVED NOV 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72493

PLACE OF DEATH
County of Madison
City of Thornton #1

Registration District No. 100
Primary Registration District No. 2178
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 52

101a

2. FULL NAME Mary C. Jensen
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 26-1839

7. AGE: Years 91, Months 2, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At the Home
(b) General nature of industry, business, or establishment in which employed (or employer): of her Son.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Andrus L. Samord.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Boel. Anderson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: J. Alma Johnson
(Address) Thornton Idaho #1.

15. Filed 10/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1930, to Oct. 7, 1930
that I last saw her alive on Oct 7, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) [signature], M.D.
10-9, 1930 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burton Ida. Date of Burial: Oct. 9th 1930.
20. Undertaker: Vern J. Keller Address: Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

NOV 6 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2016
(No. ..... St.)

State File No. 72494
Local Registrar's No. 43
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George H Bartlett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	married

6. DATE OF BIRTH: June (Month) 12. (Day) 1867 (Year)

7. AGE: 63 Yrs. Mos. 3 ds. 2
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Commission Merchant
(b) General nature of industry, business or establishment in which employed (or employer): Retired Farmer

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF Father: Frederick F Bartlett

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Jemima Laing

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo F Bartlett
(Address) 922 Dearborn St Caldwell Ida

15. Filed Oct 21 1930 E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed after complaining for some time of pain in region of heart
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E H Elmore M. D.
11-21 1930 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Canyon Hill Caldwell Ida. DATE OF BURIAL: Sept 18 1930

20. UNDERTAKER: C. J. Peckham ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

NOV 6 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 12495

Local Registrar's No. 44

1. **PLACE OF DEATH**

County of Minidaka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Thomas LeRoy Blacker Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	single

6. **DATE OF BIRTH**

9 (Month) 19 (Day) 1930 (Year)

7. **AGE**

Yrs. Mos. ds. 9

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Minidaka Co, Idaho

10. **NAME OF Father** Thomas LeRoy Blacker

11. **BIRTHPLACE OF FATHER** (State or Country) Wyoming

12. **MAIDEN NAME OF MOTHER** Myrtle Lee Hendricks

13. **BIRTHPLACE OF MOTHER** (State or Country) Marysville Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Thomas LeRoy Blacker

(Address) Rupert Ida.

15.

Filed Sept 30 1930 E V Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

9 (Month) 28 (Day) 1930 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Sept. 19 1930 **to** Sept. 28 1930

that I last saw him alive on 27 1930

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) yrs. mos. ds.

Contributory (Secondary) Prenatal Hemorrhage uterine

(Duration) yrs. mos. ds.

(Signed) E V Elmore M. D.

19 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death yrs. mos. days. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Rupert Cemetery

DATE OF BURIAL 9-29 1930

20. **UNDERTAKER** Moore

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

NOV 6 1930

CERTIFICATE OF DEATH

E

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72496

Local Registrar's No. 45

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2010

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe E Willis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH

Mar (Month) 18 (Day) 1 (Year)

7. AGE

53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF Father W M Walter

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Carthena Tilton

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Willis

(Address) Rupert Idaho

15.

Filed Oct. 17 1930 E. W. Elmore

Local Registrar

MEDICAL CERTIFICATE OF DEATH

99

16. DATE OF DEATH

Oct (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1927, to Oct. 14 1930, that I last saw her alive on Oct. 14 1930, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Arterio sclerosis. Hypertension

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) E. W. Elmore M. D.

10-17 1930 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fort Collins Col — DATE OF BURIAL ..... 19.....

20. UNDERTAKER W. A. Goodman — ADDRESS Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72497

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No. 46
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredrick William Paskett

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 28 1894

7. AGE Years 36 Months 8 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grouse Creek Box Elder Co Utah

PARENTS

10. NAME OF FATHER William P Paskett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Annie L Mecham
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grantsville Utah.

14. Informant (Address) X Wm. P. Paskett Grouse Creek Utah

15. Filed 10-17, 1930 E H Elmore Registrar.

Oct. 16 1930 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930 to Oct 16, 1930
that I last saw him alive on Oct 16, 1930
and that death occurred, on the date stated above, at 7 30 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Typhoid Fever

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Typhoid Parotiditis Sup.
Belat (duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Roland Frazier, M. D.
, 19 (Address) Rupert, Idaho

19. Place of Burial, Cremation, or Removal Grouse Creek Utah
Date of Burial 19

20. Undertaker D.E. Johnson
Address

NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72499

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015 Local Registrar's No. 48
(No. 101a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lawrance Fister Bench

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Oct. 22 1909

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21		7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Logan
(State or country) Utah

PARENTS

10. NAME OF FATHER Samuel Howard Bench
11. BIRTHPLACE OF FATHER (city or town) Logan
(State or Country) Utah.
12. MAIDEN NAME OF MOTHER Ida Cathrine Fister
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Utah

14. Informant Sam'l Bench
(Address) Logan Utah

15. Filed Oct 30, 1930 E. P. Edmunds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Oct 29, 1930
that I last saw h... alive on Oct 29, 19....
and that death occurred, on the date stated above, at 4 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Dwight E. Beam, M. D.
Oct 29, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal: Logan Utah — Date of Burial: Nov 2 19 30

20. Undertaker: D. E. Johnson — Address: Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72500

PLACE OF DEATH
County of Nezperce
City of Southwick

Registration District No. 95
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Mrs Annie Peek 90

(a) Residence. No. — St. —
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married twice Both Husbands dead now

6. DATE OF BIRTH (month, day and year): Dec 26 - 1858

7. AGE: Years 72 Months 10 Days 19 If LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework
(c) Name of employer: Noneath death

9. BIRTHPLACE (city or town) (State or country): Stillwater Minn

PARENTS
10. NAME OF FATHER: Alva Lougee
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New Hampshire State
12. MAIDEN NAME OF MOTHER: Rachel Rodgers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Maine

14. Informant
(Address) Mrs Ora Triplett

15. Filed 10-10, 1930. J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28, 1930, to Oct 7th, 1930
that I last saw her alive on Oct 7th, 1930
and that death occurred, on the date stated above, at 4 - P m.
The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease complicated with disease of the stomach
Several years (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Disease of the stomach
Many yrs - (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? In Idaho
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Only symptoms
(Signed) Russell Smith M. D.
Oct 7, 1930 (Address) Southwick Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Southwick Cemetery
Date of Burial: Oct 9th 1930

20. Undertaker: W. N. Pinson
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Broadlock

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72501

PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No.

Local Registrar's No.

(No. St. Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME F.J. Hengy

(a) Residence. No. 1702 Main St. St.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4- 1850

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Louis Hengy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Eugene Nassen
(Address) Lewiston Idaho

15. Filed 10-24, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Oct 6, 1930
that I last saw him alive on Oct 6, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? R side paralysis
(Signed) E G Brandstrom, M. D.
Oct 18, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	10/8 1930
Undertaker	Address
Nassen Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72502

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No.
(No. 928 - 10th Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

162

2. FULL NAME Vernon Bowie Willey
(a) Residence. No. 928 - 10th Ave. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) April 22 1930
7. AGE Years — Months 5 Days 8 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho
PARENTS
10. NAME OF FATHER V. S. Willey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grangeville Idaho
12. MAIDEN NAME OF MOTHER George L. Shearer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Grangeville Idaho
14. Informant V. S. Willey
(Address) Lewiston Idaho
15. Filed 10-10, 1930 J. M. Lyle By N. B. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 1, 1930
that I last saw him alive on Oct 1, 1930
and that death occurred, on the date stated above, at 2 15/10 m.
The CAUSE OF DEATH* was as follows:
Malnutrition
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Colfax Wash
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) L. B. Stockslager, M. D.
Oct 1, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grangeville Idaho. Date of Burial 19
20. Undertaker Vassar Mortuary Inc. Address Lewiston Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72503

PLACE OF DEATH
County of Nez Perce
City of Lewiston Ida

Registration District No. 96
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Mattie Norum
(a) Residence. No. 846 - 8th St St. Clarkston, Wash.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. 11 How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Norum

6. DATE OF BIRTH (month, day and year) Jan 20 - 1864

7. AGE Years 66 Months 8 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Monticello Mo.

PARENTS
10. NAME OF FATHER John B. Morton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Madison Co Ky
12. MAIDEN NAME OF MOTHER Eliza Graves
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Hannibal Mo

14. Informant (Address) John F. Norum Clarkston Washington

15. Filed 10-8 1930 J. M. Lyle Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Oct 6, 1930
that I last saw her alive on Oct 5, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma Liver (Primary)

..... (duration) ..... yrs. 3 mos. ..... ds

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? Clarkston Wash
Did an operation precede death? yes Date of Sept 30 19
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) E. G. Broadock, M. D.
Oct 7, 1930 (Address) Lewiston Ida

19. Place of Burial, Cremation, or Removal Clarkston Wash
Date of Burial 10/8 1930

20. Undertaker H. R. Merchant
Address Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72504

PLACE OF DEATH

County of Nez Perce
City of Lewiston
Registration District No. 9f
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME William A. Fabrique

(a) Residence. No. 930 - Fourth St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M		

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Clayton

6. DATE OF BIRTH (month, day and year) Oct 17th 1845

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	11	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired druggest
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Croydon Indiana

PARENTS

10. NAME OF FATHER Henry L. Fabrique
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hinsburg Vermont
12. MAIDEN NAME OF MOTHER Louisa Hinsdale
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hinsburg Vermont

14. Informant Lucille F. Clark
(Address) Lewiston Idaho

15. Filed 10-11, 1930 J. M. Lyle. Registrar
By N. B. J.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 7, 1930
that I last saw h in alive on Oct 7, 1930
and that death occurred, on the date stated above, at 30 — m.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
10/9/30 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	Oct 9 1930
20. Undertaker	Address
H. R. Merchant	Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72505

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No.
Local Registrar's No.
(No. 1110)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elmer Cecil Mustard.

(a) Residence. No. East Lewiston. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 23rd, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
----	----	14.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, I Idaho.

PARENTS

10. NAME OF FATHER O. C. Mustard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia.
12. MAIDEN NAME OF MOTHER May Nobotne.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa.

14. Informant O. C. Mustard
(Address) Lewiston, Idaho.

15. Filed 10-11, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 7th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930 to Oct 7, 1930
that I last saw him alive on Oct 6, 1930
and that death occurred, on the date stated above, at 5 a m.
The CAUSE OF DEATH* was as follows:
Influenza
(duration) yrs. mos. 5 ds.
CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W. Johnson, M. D.
10/7/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/8/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

Clark

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72506

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No.
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

44

2. FULL NAME Henry H. H. Mullin

(a) Residence. No. Lewiston Orchards St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Philamena Mullin

6. DATE OF BIRTH (month, day and year) July 25th 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	2	14	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Castle Nova Brunswick

PARENTS

10. NAME OF FATHER John Mullins.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Naomi Keefe.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs H. H. Mullins.
(Address) Lewiston Orchards

15. Filed 10-12-1930 J. M. Lyle Registrar
By Mrs.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W O Clark, M. D.
10/11, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	10/11 1930
20. Undertaker	Address
Vassar Mortuary Inc.	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

"Habel"

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72507

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No.
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

119

2. FULL NAME Donald L. Penner

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 25 - 1929

7. AGE: Years 1, Months 6, Days 14. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweetwater Idaho

PARENTS

10. NAME OF FATHER: Claud R. Penner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebraska.
12. MAIDEN NAME OF MOTHER: Thelma Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mo

14. Informant: Claud R Penner
(Address): Riparia Wash

15. Filed 10-16, 1930 J. M. Ryle By N.B. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1930, to Oct 9, 1930
that I last saw him alive on Oct. 9, 1930
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:
Epidemic Colitis.
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Riparia Wash.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? physical signs.
(Signed) William J. Habel, M. D.
Oct. 10, 1930 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston
Date of Burial: 10/10 1930

20. Undertaker: Vassar Mortuary
Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

"Stockslager"

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72508

PLACE OF DEATH
County of Nez Perce
City of Near Lewiston

Registration District No. 95
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

204

2. FULL NAME (Lafe Mounce) Marquis de Lafayette Mounce

(a) Residence. No. Home in Tammany St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Anna Mounce

6. DATE OF BIRTH (month, day and year) Aug 15 - 1866

7. AGE Years 64 Months 1 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) General farming
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Isaac Mounce
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Priscilla Timmons
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Michigan

14. Informant Mrs Anna Mounce
(Address) Lewiston

15. Filed 10-16, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19, to, 19
that I last saw him alive on —, 19
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows: Sudden death probably Coronary Thrombus
— (duration) — yrs. — mos. ds.
CONTRIBUTORY (Secondary) Unknown
✓ (duration) ✓ yrs. ✓ mos. ✓ ds.

18. Where was disease contracted if not at place of death? at place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) L. B. Stockslager M. D.
10/14, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 10/12 1930

20. Undertaker Vassar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Duncan

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72509

PLACE OF DEATH

County of Nez Pefce.

City of Lewiston.

Registration District No. 96

Primary Registration District No.

Local Registrar's No.

(No. 708 12th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Lyle Norman Henley.

(a) Residence. No. 708 12th, Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 24th, 1922.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7.	11.	18.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bison, S. D.

PARENTS

10. NAME OF FATHER L. L. Hanley.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) S. D.

12. MAIDEN NAME OF MOTHER Lillian Larson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) S. D.

14. Informant L. L. Henley
(Address) Lewiston, Idaho.

15. Filed 10-14, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 12th, 1930.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to October 12 1930
that I last saw h~~im~~ alive on October 12, 1930
and that death occurred, on the date stated above, at 3 30. P m.
The CAUSE OF DEATH* was as follows:
Heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chorea at Epileptic Spasms

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) La Fayette Dunman M. D.
10/18/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/18/30. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72510

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 4
Primary Registration District No.
(No. 13th and 24th St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

32

2. FULL NAME Hal Platt Blackpole

(a) Residence. No. 13th and 24th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 13 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	7	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho.

PARENTS

10. NAME OF FATHER Frank Blackpole
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewiston Idaho.
12. MAIDEN NAME OF MOTHER Joan Platt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kendrick Idaho.

14. Informant Frank Blackpole
(Address) Lewiston Idaho.

15. Filed 10-27, 1930 H. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 28, 1930, to Oct 26, 1930
that I last saw him alive on Oct 25, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Tubercular meningitis.

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Spinal fluid test.
(Signed) Paul D. Johnson M. D.
Oct 27, 1930 (Address) Lewiston Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	10/28 1930

20. Undertaker Mason Mortuary Inc. Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72511

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 6

Primary Registration District No.

Local Registrar's No.

(No. 1232 Rigby Lane.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

105

2. FULL NAME Burgess Ward.

(a) Residence. No. 1232 Rigby Lane. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 9th, 1856.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74.	7.	14.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10. NAME OF FATHER Abinzer Ward.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va.

12. MAIDEN NAME OF MOTHER Martha Carper.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) W. Va.

14. Informant V. A. Ward.
(Address) Lewiston, Idaho.

15. Filed 11-4, 1930 J M Hyde Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 23rd, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 23rd, 1930, that I last saw h alive on, 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Asthma
(duration) 8 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C Carlson, M. D.

10/25/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/25/30. 19
20. Undertaker	**Address**
Brower-Wann Company.	Lewiston, Idaho

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72512

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No.
Local Registrar's No.
(No. 324 12th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Ophelia Wilsey.

(a) Residence. No. 324 12th, Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of C. H. Wilsey.

6. DATE OF BIRTH (month, day and year) May 10th, 1868.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62.	5.	14.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cannville, Indiana.

PARENTS

10. NAME OF FATHER Barnard Goucher.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. J.
12. MAIDEN NAME OF MOTHER Eliza Sayer.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. J.

14. Informant C. N. Wilsey.
(Address) Lewiston, Idaho.

15. Filed 11-4, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 24th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E. M. Brower Coroner
M. D.
10/26/30., 19... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/26/30. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72513

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.

Registration District No. 96
Primary Registration District No.
(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

10-

2. FULL NAME Martha W. Foster.

(a) Residence. No. St. Pierce, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: T. J. Foster.

6. DATE OF BIRTH (month, day and year): December 26th, 1880.

7. AGE: Years 49. Months 9. Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Osakis, Wisconsin.

PARENTS

10. NAME OF FATHER: Christian Larson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark.
12. MAIDEN NAME OF MOTHER: Caroline Iverson.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark.

14. Informant: T. J. Foster
(Address) Pierce, Idaho.

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 25th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-9-30, 19, to 10-25, 1930
that I last saw her alive on 10-25-1930, 19
and that death occurred, on the date stated above, at 9:20 p. m.
The CAUSE OF DEATH* was as follows:
Cardiac asthma.

(duration) 22 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms.
(Signed) H. Rouse M.D., M. D.
10/27/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 10/27/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72514

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bernard Young. 7

(a) Residence. No. Lewiston Orchards. xSt
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ford,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER G. C. Young.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Mabel Carry.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant G. C. Young.
(Address) Lewiston, Idaho.

15. Filed 11-3 1930 J. M. Lyle
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 26th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1930, to Oct. 26 1930, that I last saw him alive on Oct. 24 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Bronchio pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Lyle, M. D.
10/28/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/28/30. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Stockton

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72515

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No.
(No. St Joseph's)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

16112

2. FULL NAME Lola B. Skow

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 8 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Near Lapwai Ida

PARENTS

10. NAME OF FATHER N. P. Skow Jr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington
12. MAIDEN NAME OF MOTHER Helen Goodwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) So Dakota

14. Informant N. P. Skow
(Address) Lapwai Idaho

15. Filed 10-14, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930 to Oct 12, 1930
that I last saw her alive on Oct 11, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Meningeal Hemorrhage
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Birth Injury
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) L B Stockwell M. D.
10/14, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	10/12 1930
20. Undertaker	Address
Vassars Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Bradshaw

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72516

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No.
(No. St Joseph Hospital)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Bryce Lyle

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16- 1924

7. AGE	Years	Months	Days	If LESS than 1 day,
	6	1	28	hrs, or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Ernest Lyle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Nebraska~~ Wash
12. MAIDEN NAME OF MOTHER Ethel Henry.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Calif.

14. Informant
(Address)

15. Filed 10-16, 1930 J. M. Lyle By. M.S.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 14, 1930, that I last saw him alive on Oct 14, 1930 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis
Appendicitis. acute. perforated
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 12, 1930
Was there an autopsy? no
What test confirmed diagnosis? Op. and lab.

(Signed) Ralph M. Aller M. D.
Oct 14, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	10/16 1930
20. Undertaker	Address
Cassan Mortuary	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Lyle

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72517

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No.

Local Registrar's No.

(No. 531 Snakeriver Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Hudson Ellithorpe.

(a) Residence. No. 531 Snakeriver Avenue. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 21st, 1852.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78.	3.	25.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10. NAME OF FATHER R. M. Ellithorpe.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER ------ Gage.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N. Y.

14. Informant Nattie J. Fulwyder

(Address) Sparks, Nevada.

15. Filed 10 28, 1930 J M Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 16th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...

that I last saw h... alive on ....., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Never attended, Returned but Knows he had a very large thyroid gland for several years

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J M Lyle, M. D.

10/20/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/20/30. 19
20. Undertaker	**Address**
Brower-Wann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 8 1930 Original

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72518

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No.
(No. St Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Scotty Joy
(a) Residence. No. Ahsahka Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 24-1890
7. AGE Years 40 Months 4 Days 25 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C.P. R.R. Co
9. BIRTHPLACE (city or town) (State or country) Nebr.

PARENTS
10. NAME OF FATHER John W Joy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Amy. Helen McGuire
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nebr.

14. Informant Harry M Joy
(Address) Seattle Wash

15. Filed 10-21, 1930 J M Tyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1930, to Oct 19th, 1930
that I last saw him alive on Oct 19th, 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Empyema Gall Bladder
(duration) yrs. mos. 26 ds.

18. Where was disease contracted if not at place of death? Orofino Idaho
Did an operation precede death? Yes Date of Oct 3 30
Was there an autopsy? Yes
What test confirmed diagnosis? Operation & autopsy
(Signed) [illegible] Carssow, M. D.
Oct 21st, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Ida
Date of Burial 10/21 1930
20. Undertaker Vassar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72519

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No.

Local Registrar's No.

(No. 1607 G Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nellie Geidl.

(a) Residence. No. 1607 G Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 13th, 1884.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46.	2.	7.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER Patrick Lydon.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Mae Geidl
(Address) Lewiston, Idaho.

15. Filed 10-24, 1930 J. M. McLyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 20th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 20, 1930
that I last saw her alive on Oct 20, 1930
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Diabetic Coma

Valvular Heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
10/22/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	10/22/30. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72520

PLACE OF DEATH

County of Nez Perce
City of Gifford

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elias Juckey

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Caroline Juckey

6. DATE OF BIRTH (month, day and year) May 3 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	5	1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER John Juckey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mabel Hicks
(Address) Gifford

15. Filed Oct 5, 1930 E. E. Watts
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-15, 1930, to 10-4, 1930
that I last saw h~~im~~ alive on 10-3, 1930
and that death occurred, on the date stated above, at 5:40 A m.
The CAUSE OF DEATH* was as follows:
Dilitation Aorta

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) E. E. Watts, M. D.
10-5, 1930 (Address) Gifford

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gifford Idaho	10-6 1930

20. Undertaker Craigmont Hdwe Co
Address Craigmont Idaho

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72521

PLACE OF DEATH

County of Oneida

City of Malad

Registration District No. 26

Primary Registration District No. 2069

Local Registrar's No. 1

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ella Owens Coddington

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Harry Coddington

6. DATE OF BIRTH (month, day and year): Nov. 28. 1890

7. AGE: Years 39 | Months 10 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): St. John Idaho

PARENTS

10. NAME OF FATHER: Ephraim E. Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Amelia Ann Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Villard Ut.

14. Informant: Beth D Jones
(Address) Ogden Utah

15. Filed 10-31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Oct 21, 1930

that I last saw her alive on Oct 9, 1930

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

accidental fall
becoming entangled
with cord strangulation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Nemathemia and
mitral regurgitation (duration) ? yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) [signature], M. D.

10/23, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Ida | Date of Burial: Oct. 23 1930

20. Undertaker: J. Guy Benson | Address: Malad Ida

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72523

PLACE OF DEATH
County of Oneida
City of Holbrook Ida

Registration District No. 26
Primary Registration District No. 2069
Local Registrar's No. 39

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME Warren Hugh Sweeten

(a) Residence. No. Holbrook Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White -
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 10. 1883

7. AGE Years 47 Months 6 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Mendon
(State or country) Utah

PARENTS

10. NAME OF FATHER Robert Sweeten
11. BIRTHPLACE OF FATHER (city or town) Brook
(State or Country) Canada
12. MAIDEN NAME OF MOTHER Amanda Hagle
13. BIRTHPLACE OF MOTHER (city or town) Brook
(State or Country) Canada

14. Informant Colen H Sweeten
(Address) Holbrook Idaho

15. Filed 10-31, 1930. J. M. Kerr
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/14, 1930, to 10/18, 1930
that I last saw him alive on 18, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:
Pentonitis

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Ruptured append.
..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of 10/14/30
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature] M. D.
10/20, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Holbrook Ida
Date of Burial Oct. 23 1930

20. Undertaker J. Guy Benson
Address Malad Ida

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72524

PLACE OF DEATH

County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 38

483

2. FULL NAME Ellen Jones
(a) Residence. No. Malad Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Lubin Jones

6. DATE OF BIRTH (month, day and year): Feb. 28 - 1882

7. AGE: Years 48, Months 7, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Malad Idaho

PARENTS
10. NAME OF FATHER: Wm E. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Lucretia Lusk
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Lubin Jones
(Address): Malad Idaho

15. Filed 10-31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 8 1930 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/20/, 1926, to Oct 8, 1930
that I last saw her alive on Oct 8, 1930
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Stroke
..... (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) [signature], M.D.
10/22, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Idaho
Date of Burial: Oct. 11 1930

20. Undertaker: J. Guy Benson
Address: Malad Idaho

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72525

PLACE OF DEATH

County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2064
Local Registrar's No. 37

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dale Neil Vaughan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 4 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	1	5	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho

PARENTS

10. NAME OF FATHER Dale Vaughan

11. BIRTHPLACE OF FATHER (city or town) Malad
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Isabelle Hughes

13. BIRTHPLACE OF MOTHER (city or town) Malad
(State or Country) Idaho

14. Informant Dale Vaughan
(Address) Malad Idaho

15. Filed Oct 31, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1928 to Oct 6, 1930
that I last saw h in alive on Oct 3, 1930
and that death occurred, on the date stated above, at 8P m.
The CAUSE OF DEATH* was as follows:
Hydrocephalus
Acute

..... (duration) ..... yrs. 20 mos. ..... ds.

CONTRIBUTORY (Secondary) none

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) W. A. Nelson M. D.
10/7, 1930 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Idaho	Oct. 9 1930

20. Undertaker	Address
J. Guy Keeman	Malad Idaho

RECEIVED NOV 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72526

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069

Local Registrar's No. 36

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gail Jones

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 16. 1917

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
13		19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Malad
(State or country) Idaho

PARENTS

10. NAME OF FATHER David E. Jones Jr.

11. BIRTHPLACE OF FATHER (city or town) Malad
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER Clarasettie Price

13. BIRTHPLACE OF MOTHER (city or town) Malad
(State or Country) Idaho

14. Informant David E. Jones Jr.
(Address) Malad Idaho

15. Filed 10-31, 1930 J. M. Kerns
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Oct 5, 1930
that I last saw him alive on Oct 5, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:
Influenza from Scratch
on finger.

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) J. M. Kerns M. D.
10-30, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Malad Ida	Oct. 1930

20. Undertaker	Address
J. Guy Benson	Malad Ida

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72527

PLACE OF DEATH

County of Owyhee
City of Grand View
Registration District No. 74
Primary Registration District No. 2151
Local Registrar's No. 61
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Samuel Enoch Gress

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 1st, 1846

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Monroe, Virginia

PARENTS

10. NAME OF FATHER Robert Gress
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Margaret Connor
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Sarah M. Jensen
(Address) Grand View

15. Filed Nov. 11, 1930 W. J. Eckenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 6th, 1929, to Nov. 6th, 1930
that I last saw him alive on Nov. 5th, 1930
and that death occurred, on the date stated above, at 2:15P. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage, left side
Paralysis
Senility
(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Wm. J. Eckenbeck, M. D.
Nov. 7th, 1930 (Address) Grand View

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grand View	Nov. 7 1930

20. Undertaker	Address
C. G. Zacher	Mt. Home.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72528

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 74
Primary Registration District No. 2151
Local Registrar's No. 6 2

Died enroute to Boise Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Raymond Arambarri
(a) Residence. No. ..... St. Grand View, Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 9-1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	4		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Boise, Idaho
(State or country)

PARENTS

10. NAME OF FATHER John Arambarri
11. BIRTHPLACE OF FATHER (city or town) Spain
(State or Country)
12. MAIDEN NAME OF MOTHER Ynanda Echeverria
13. BIRTHPLACE OF MOTHER (city or town) Spain
(State or County)

14. Informant Juanita Echeverria
(Address)

15. Filed Nov. 11, 1930 W J Pickenbrock
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 8th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov. 5th, 1930 to Nov. 8th, 1930
that I last saw him alive on Nov. 8th, 1930
and that death occurred, on the date stated above, at 7:30 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Diarrhoea and enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm J. Eckenbrock, M. D.
Nov. 8th, 1930 (Address) Grand View

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Johns Cemetery	Nov. 10 1930
20. Undertaker	Address
Schreiber & McCann	Boise, I

PHYSICIAN please

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72529

PLACE OF DEATH

County of Power
City of American Falls

Registration District No. 25
Primary Registration District No. 2072
Local Registrar's No. 24

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Hiriam Orders

(a) Residence. No. Six Miles south of Am Falls St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Flora Orders

6. DATE OF BIRTH (month, day and year): Feb 16 1846

7. AGE: Years 83, Months 7, Days 16. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Joshaway Orders
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: notknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: J. R. Orders
(Address) American Falls Idaho

15. Filed Oct. 4, 1930 Gunnison Nolty Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 2nd 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1930, to Oct 2, 1930
that I last saw him alive on Sept 28, 1930
and that death occurred, on the date stated above, at 8.45 P m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. F. Schiltz, M. D.
10/3/30, 19 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: I.O.O.F. Cemetary
Date of Burial: 10-5 1930

20. Undertaker: A W Davis
Address: American Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72530

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 21

Primary Registration District No. 2079

Local Registrar's No. 21

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

120

2. FULL NAME Mabel Wagner

(a) Residence. No. Aberdeen, Idaho St.
(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henery Wagner

6. DATE OF BIRTH (month, day and year) July 10th

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33	3	21	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Kans
(State or country)

PARENTS

10. NAME OF FATHER A. Shearer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Katie Perry

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Henry Wagner
(Address) Aberdeen, Idaho

15. Filed Nov. 1, 1930 Gwenin Wolf Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 31, 1930, that I last saw h[illegible] alive on Oct 31, 1930, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Jedon atrophy of the liver

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 20 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 14 1930

Was there an autopsy? no

What test confirmed diagnosis? Blood & urine

(Signed) M. C. McCammon, M. D.

Oct 31st 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
I.O.O.F Cemetary	Nov-, 193

20. Undertaker A. W. Davis Address American Falls, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. #72531

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

92

2. FULL NAME Mary Jane Dolan
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles Dolan

6. DATE OF BIRTH (month, day and year) March 17 - 1884

7. AGE Years 46 Months 6 Days 13 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scranton Penn

PARENTS
10. NAME OF FATHER Thomas King
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Mary Jane Thornton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Mr Charles Dolan
(Address) Wallace Idaho

15. Filed Oct 3, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22nd, 1930, to Sept 30, 1930
that I last saw her alive on Sept 30 1930
and that death occurred, on the date stated above, at 6 45 P m.
The CAUSE OF DEATH* was as follows:
Broken Cardiac Compensation & Thrombosis.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptomatology
(Signed) W. C. Lindsay, M. D.
10/1, 1930 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace Idaho
Date of Burial Oct 3 1930

20. Undertaker J. A. Bever Ward Und Co.
Address Wallace, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72532

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 91

2. FULL NAME Darleen Dovenberg
(a) Residence. No. Wallace, Idaho St. 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 3 - 1930

7. AGE Years Months 2 Days 23 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER Earl Dovenberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn.
12. MAIDEN NAME OF MOTHER Ester Doebbert
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minn.

14. Informant Earl Dovenberg
(Address) Wallace, Idaho

15. Filed 9-28, 1930 L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23, 1930, to Sept 26, 1930
that I last saw her alive on Sept 25, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Pneumonia (Pulmonary)

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Diagnosis
(Signed) H. W. Rolf M. D.
Sept 27, 1930 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Sept 28 1930
20. Undertaker J. A. Rowe Ward Und Co. Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72533

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 90

2. FULL NAME Oscar Wilson
(a) Residence. No. near Enaville Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elida Wilson

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Finland

PARENTS
10. NAME OF FATHER: not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Finland
12. MAIDEN NAME OF MOTHER: not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Finland

14. Informant: John Andrew Wilson
(Address) Enaville Idaho

15. Filed Sept 17, 1930 L. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9, 1930, to Sept 14, 1930
that I last saw him alive on Sept 14, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:
Myocardial Degeneration
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? Physical Examination
(Signed) R. Werbick M. D., M. D.
Sept 16, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Enaville Idaho. Date of Burial: Sept 17 1930.

20. Undertaker: B. G. Worstell Address: Wallace

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72534

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 11011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 89

2. FULL NAME William Carlson
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	75	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Hecla Mng. Co.

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Joe Johnson
(Address) Wallace, Idaho

15. Filed Sept 14, 1930 F. L. Tingley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to Sept 11, 19..., that I last saw him alive on Sept 11, 19..., and that death occurred, on the date stated above, at 7:30 P.m.
The CAUSE OF DEATH* was as follows:
Pneumonia
Bronchial
(duration) yrs. Several mos. ds.
CONTRIBUTORY (Secondary) Exposure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No none
What test confirmed diagnosis?
(Signed) H. C. Mowery Coroner M.D.
1/12, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho
Date of Burial: Sept 14 1930

20. Undertaker: J. A. Bevis Ward Und. Co.
Address: Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72535

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 88

2. FULL NAME Ella Harvey
(a) Residence. No. Mullan, Idaho St. Mullan, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Hall Harvey.
6. DATE OF BIRTH (month, day and year) Aug 16-1864
7. AGE 66 Years 1 Months 25 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS
10. NAME OF FATHER Joseph Kennedy.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Hall Harvey.
(Address) Mullan, Idaho.
15. Filed Sept 14, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 11 1930
Sept (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1930, to Sept 11, 1930
that I last saw her alive on Sept 11, 1930
and that death occurred, on the date stated above, at 12:45 m.
The CAUSE OF DEATH* was as follows:
Heart Failure
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Diabetes Malitus
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Haine's
(Signed) F. W. Kolf, M. D.
Sept 12, 1930 (Address) Mullan Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Mullan, Idaho
Date of Burial Sept 14 1930
20. Undertaker J. A. Bever Ward Und Co.
Address Wallace, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72536

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70 1961
Primary Registration District No. Mullan
(No. 108 Wallace-Highway)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

2. FULL NAME Mary Ann Allison
(a) Residence. No. 108 Wallace Highway St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of C. E. Allison

6. DATE OF BIRTH (month, day and year) Sept. 13th 1877

7. AGE: Years 52, Months 11, Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dayton Ohio

PARENTS
10. NAME OF FATHER: Chas E. Kidney
11. BIRTHPLACE OF FATHER (city or town) (State or Country): New York State
12. MAIDEN NAME OF MOTHER: Alice Bucher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: C. E. Allison
(Address) Mullan Ida

15. Filed Sept 13, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) ~~XX~~ (Day) 11 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw her alive on Sept ~~XX~~ 11, 1930
and that death occurred, on the date stated above, at 12 noon
The CAUSE OF DEATH* was as follows:
Heart Disease
Chrisian Scientist
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Mowrey Corbett
9/13, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Idaho — Date of Burial: Sept 13th 1930

20. Undertaker: Bruce G. Worstell — Address: Wallace

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72537

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 86

2. FULL NAME Victor C. Wisenthal

(a) Residence. No. #3 Cottonwood Ave St. Harvard Ida. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6. DATE OF BIRTH (month, day and year) Feb 28 - 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	6	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Man
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Eugene C Wisenthal
(Address) Harvard Ida.

15. Filed Sept 13, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from \, 19..., to ..., 19...
that I last saw h[illegible] alive on ..., 19...
and that death occurred on the date stated above, at 8 p.m.
The CAUSE OF DEATH* was as follows: Apparently Legal failure as had been dead in chair for Week.
(duration) ... yrs. few Weeks.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) A. C. Moriarty Coroner
9/0, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Spokane Wash	Sept 13 1930
20. Undertaker J. A Beer Ward and Co	Address Wallace, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED OCT 21 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72538

PLACE OF DEATH

County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1911
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 85

119

2. FULL NAME Gertrude Evelyn Walker

(a) Residence. No. Genn, Idaho St. Genn Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 17 - 1925

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	9	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Genn Idaho

PARENTS

10. NAME OF FATHER Everett Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tacoma Wash
12. MAIDEN NAME OF MOTHER Violet Monroe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mr Everett Walker
(Address) Genn, Idaho

15. Filed Sept 7, 1930 F. K. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 4, 1930
that I last saw her alive on Sept 4, 1930
and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

4 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) James R Bean, M. D.
9/6/30, 19 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	Sept 7 1930
20. Undertaker J. A. Bever	Address
Ward Cud Co.	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72539

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 56

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Tillie Luella Schenck

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of William B. Schenck

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	2	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mitchell Co. Iowa

PARENTS

10. NAME OF FATHER Reuben Allen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Margret Counsell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Grace Dettinger
(Address) Kellogg, Idaho

15. Filed Oct. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct in, 1930, to Oct 24th, 1930
that I last saw h[illegible] alive on Oct 23rd, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) old age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes. Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? Symptoms
(Signed) H. C. Lindsay, M. D.
10/25, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood	Oct 27 1930
20. Undertaker	Address
M. E. Hunter	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72540

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 55

PLACE OF DEATH
County of Shoshone
City of Kellogg
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Costa

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
10	—	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER Louis Costa
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Mary ?
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Sassio Costa
(Address) Kellogg Idaho

15. Filed Oct. 30, 1930 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 20, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1930, to Oct. 20, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9:30 a. m.
The CAUSE OF DEATH* was as follows:

Manipulation during delivery of mother.
(duration) yrs. mos. 0 ds.
CONTRIBUTORY (Secondary) Transverse position.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) T. W. Laraway M. D.
10-21-, 1930. (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Oct 21, 1930

20. Undertaker	Address
M. C. Thornhill	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72541

PLACE OF DEATH
County of Shoshone Idaho
City of Kellogg
Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 54
(No. 113)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Roberta Beau Miles
(a) Residence. No. Kellogg - Idaho St. 205 N Brown
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Feb 4th 1930
7. AGE: Years | Months: 8 | Days: 19 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Kellogg Ida
PARENTS
10. NAME OF FATHER: Scott Melvin Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Hardy Arkansas
12. MAIDEN NAME OF MOTHER: Edna Swenson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Cordston Alberta Canada
14. Informant: Scott Miles
(Address)
15. Filed Oct. 30, 1930 Mrs. H. P. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10/ (Month) 27 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows: Was not in attendance was called after death, and from history, believe, acute enteritis the cause of death (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) H. L. Lindsay, M. D.
10/27, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood	10/29 1930
20. Undertaker: M C Shanahan	Address: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72542

PLACE OF DEATH
County of [redacted] Shoshone
City of Smelterville

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 53

(No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Millie Etta Sullivan

(a) Residence. No. Smelterville St. Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. 9 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Earl G Sullivan

6. DATE OF BIRTH (month, day and year) Nov 15 - 18[illegible]

7. AGE	Years	Months	Days	If LESS than 1 day, hours or minutes
	40	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Troy

PARENTS

10. NAME OF FATHER Francis M. [illegible]
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Matilda C Kear[illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Stuart[illegible] Mo.

14. Informant Fred W Johnson
(Address) Smelterville Ida

15. Filed Oct 30, 1930 Mrs. Helen [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Oct 17, 1930
that I last saw her alive on Oct 12, 1930
and that death occurred, on the date stated above, at 12:30 a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of uterus
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Melena - Bowel Obstruction
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) T W Laraway M. D.
10-17-1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pullman, Wash	Oct 19 1930
20. Undertaker	Address
M. P. Thornhill	Kellogg Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72543

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 53

PLACE OF DEATH
County of Shoshone
City of Kellogg.
(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Vernon Dale Turner
(a) Residence. No. 609-3-St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS
10. NAME OF FATHER Fred E. Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Smithfield, Utah
12. MAIDEN NAME OF MOTHER Mary Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Banff Alta.

14. Informant Mary A Turner
(Address) Kellogg Idaho.

15. Filed Oct 30, 1930 Mrs. Helen M. Bride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-3-, 1930, to 10-3-, 1930, that I last saw him alive on 10-3-, 1930 and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:

Cachexia - Malnutrition.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical.

(Signed) T. L. Caraway M. D.
10-8-, 1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kellogg Idaho	Oct 5 1930
20. Undertaker M. C. Shoemaker	Address Kellogg Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72544

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 57

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

113

2. FULL NAME Gerald Melville Miles

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): —

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 27, 1930

7. AGE Years | Months 6 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS

10. NAME OF FATHER James G. Miles
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hardy Ark.
12. MAIDEN NAME OF MOTHER Gwendolyn Fisher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Palouse Wash

14. Informant Mrs. Gwendolyn Miles
(Address)

15. Filed Oct. 30, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16, 1930, to Oct 3, 1930
that I last saw him alive on Oct 3, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Diarrhea & enteritis
..... (duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) T. R. Mason, M. D.
Oct 8, 1930 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood
Date of Burial: Oct 5 1930

20. Undertaker: M. C. Thurbert
Address: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72545

Local Registrar's No. 9

PLACE OF DEATH

County of Teton

City of Tetonia

Registration District No. 77

Primary Registration District No. 3176

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonora Hansen

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Driggs, Idaho.

PARENTS

10. NAME OF FATHER Seymour B. Hansen

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Weston Idaho

12. MAIDEN NAME OF MOTHER Ruth B. Driggs

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Driggs, Idaho.

14. Informant Seymour B Hansen
(Address) Tetonia Idaho

15. Filed 10-10-, 1930 Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows:
Inflamation of Stomache
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Martha Marker, Registrar
10-8-, 1930 (Address) Driggs, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clawson Idaho	10-10- 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC'D NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72546

PLACE OF DEATH
County of Jerome Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hospital)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 186

1844

2. FULL NAME James Elmer Fuller

(a) Residence. No. Eden Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Estella K. Fuller

6 DATE OF BIRTH (month, day and year) July 13 - 1882

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrical operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Boise
(State or country) Idaho

PARENTS

10 NAME OF FATHER James L. Fuller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York State

12 MAIDEN NAME OF MOTHER Celia Amanda Decker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Minnesota

14 Informant Lowry A. Murphy
(Address) Hagerman Ida.

15 Filed Nov 5 1930 Elizabeth J. Sowell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct (Month) 30 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 28th, 1930, to Oct 30th, 1930
that I last saw him alive on Oct 30, 1930
and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:
Perforation Jejunum Traumatic accidental (Bursting Trug struck in abdomen by Swinging tree)
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Peritonitis General Acute
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Near Eden Jerome Co Ida
Did an operation precede death? Yes Date of Oct 28th 30
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) Duncan A. Graeme, M. D.
11/2/30 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Cemetery	Nov 2 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls Ida.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72548

PLACE OF DEATH

County of Twin Falls Idaho
City of Kimberly.
Registration District No. 37
Primary Registration District No. 2081
Local Registrar's No. 184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. **FULL NAME** Marion Pollard.

(a) Residence. No. Kimberly, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 25th, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	11	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Twin Falls,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER F.H.Pollard

11. BIRTHPLACE OF FATHER (city or town) Indiana
(State or Country)

12. MAIDEN NAME OF MOTHER Dorothy L. Pritchett.

13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant F.H. Pollard,
(Address) Kimberly, Ida.

15. Filed Oct. 29., 1930 Elizabeth J. Smith
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct- 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct- 23, 1930 to Oct- 24, 1930
that I last saw h.. alive on Oct- 23, 1930
and that death occurred, on the date stated above, at 1 A m.
The CAUSE OF DEATH* was as follows:
Ileo Colitis
(duration) yrs. mos. 3- ds.
CONTRIBUTORY (Secondary) Acidosis -
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? -
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Clinical & Laboratory
(Signed) J.H. Davis, M. D.
Oct-25, 1930 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Idaho	Oct. 26 1930

20. Undertaker	Address
P.J. Grossman	Twin Falls Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., **Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.** But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: **(a) Spinner, (b) Cotton Mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile Factory.** The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as **Day laborer, Farm laborer, Laborer—Coal mine, etc.** Women at home, who are engaged in the duties of the household only (not paid **Housekeepers,** who receive a definite salary), may be entered as **Housewife, Housework,** or **At home,** and children, not gainfully employed, as **At school** or **At home.** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: **Farmer (retired 6 yrs.)** For persons who have no occupation whatever, write **None.**

STATEMENT OF CAUSE OF DEATH—Name first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: **Cerebrospinal fever** (the only definite synonym is "Epidemic cerebrospinal meningitis"); **Diphtheria** (avoid use of "Croup"); **Typhoid fever** (never report "Typhoid Pneumonia"); **Lobar pneumonia; Bronchopneumonia** ("Pneumonia," unqualified, is indefinite); **Tuberculosis of lungs, meninges, peritoneum,** etc., **Carcinoma, Carcoma,** etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; **Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.** The contributory (secondary or intercurrent affection need not be stated unless important. Examples: **Measles** (disease causing death), **29 ds.; Bronchopneumonia** (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL **septicemia,**" "PUERPERAL **peritonitis,**" etc. all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as **probably** such, if impossible to determine definitely. Examples: **Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.** The nature of the injury, as fractured skull, and consequences (e. g. **sepsis, tetanus**) may be stated under the head of "Contributory."

DUTY OF LOCAL REGISTRARS—Mail all death certicates filed with you to the State Registrar on or before the fifth of the following month; keeping a copy of same for your local record.

Enter date of filing on the certificate immediately and give the certificate its registered number, beginning each year with number one. Carefully examine each certificate before issuing the burial permit and call the attention of the undertaker or other person to any omissions. If the information cannot be secured, it should be plainly stated unknown.

Registrars should be careful to see that the medical statement of death is supplied. If no physician attended the deceased and it is probable that death was due to unlawful or suspicious means, the case should be referred to the Coroner for investigation and statement of the cause of death; other deaths than above without medical attendance should be referred to the Health Officer (if a physician), but when there is no such health officer, and only in such cases, the local registrar may make the return upon the information of relatives or friends of the deceased having adequate knowledge of the facts.

Do not accept a certificate of death signed only by a midwife.

B 10/25/20 2 # 9

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72549

County of [illegible]
City of Amsterdam
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 183

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Velma Mary Huddleston

(a) Residence. No. Amsterdam St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): July 3 1899

7. AGE: Years 31 | Months 3 | Days 20 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Wife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER W R Skinner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Maggie Andrews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant W. P. Skinner
(Address) Amsterdam

15. Filed Oct. 29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 23 5:45 a m 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Filer Idaho
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? General

(Signed) J E Burke Coroner
Oct 23, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hagerman | Date of Burial: Oct 24 1930

20. Undertaker: J E Burke | Address: Twin Falls

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72550

Local Registrar's No. 182

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Gen. Hospital
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

1180

2. FULL NAME Eva Vandora Jensen

(a) Residence. No. Filer Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 0 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emil C. Jensen

6 DATE OF BIRTH (month, day and year) Dec. 3 1890

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Herbert A. Chase
11 BIRTHPLACE OF FATHER (city or town) (State or country) Iowa
12 MAIDEN NAME OF MOTHER Lena Hyatt
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant A. B. Chase
(Address) Filer Ida Route #1

15 Filed Oct. 29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21 -, 1930, to Oct 23 -, 1930, that I last saw h.. alive on Oct 23 -, 1930, and that death occurred, on the date stated above, at 10:50P m.

The CAUSE OF DEATH* was as follows:

Toxemia
(duration) yrs. 24 mos. hours ds.
CONTRIBUTORY (Secondary) Intestinal obstruction
(duration) yrs. 90 mos. hours ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Oct 23-1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) F. A. Dwight, M. D.
Oct. 24, 1930 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Thornton, Iowa	
20. Undertaker White Mortuary, Inc.	Address Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72551

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 181

(No. 99A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel Alford

(a) Residence. No. [illegible] Twin Falls St. Dr Leets
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Dec 10 1875
7. AGE: Years 54 | Months 10 | Days 10 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS
10. NAME OF FATHER: John Alford
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Jas W. Alford
(Address) 1588-15th St Ogden Utah

15. Filed Oct, 29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 22, 1930, that I last saw him alive on Oct 20-, 1930, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:
acute Bronchitis
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
Exposure (duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) H N Leets M. D.
10-22, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Oct 22 1930
20. Undertaker: F E Yeates — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72552

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No. 180

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace S. Hogue Clark

(a) Residence. No. Hansen Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): April 20

7. AGE: Years 34 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: A. S. Hogue

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Martha Brown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: D. A. Clark
(Address)

15. Filed Oct. 29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October, 18, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1930, to Oct. 17, 1930
that I last saw her alive on Oct 17 1930
and that death occurred, on the date stated above, at 10:15 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary): Herpes Zoster

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Charley R. Scott, M. D.
Oct 21, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Oct 22 1930

20. Undertaker: J. F. Grossmire — Address: Twin Falls

RECEIVED NOV 8 1930

PLACE OF DEATH

County Twin Falls

City of Castleford

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72553

Local Registrar's No. 179

74A

2. FULL NAME Ho" B Hendricks

(a) Residence. No. Twin Falls St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 20 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) General Work

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Hendricks

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant William Hendricks
(Address) Twin Falls

15. Filed Oct. 29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—
that I last saw h— alive on — 19—
and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows: died Unattended
white Working in field
Chronic Valvular heart disease

Probable (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrage

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General

(Signed) F E Drake Coroner, M.D.

Oct 17, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Oct 19 1930

20. Undertaker F E Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7255

PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of Do. Primary Registration District No. 2085
(No. Twin Falls Co Hospital)
Local Registrar's No. 178
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cora Blanche Stumpf.

(a) Residence. No. 158 Washington Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of: L. F. Stumpf.

6 DATE OF BIRTH (month, day and year): Nov 18 1883

7 AGE: Years 44 | Months 10 | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kansas.

PARENTS
10 NAME OF FATHER: McKean.
11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know.
12 MAIDEN NAME OF MOTHER: McMillan
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know.

14 Informant: L. F. Stumpf
(Address): Twin Falls. Idaho

15 Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 12 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1930, to Oct. 12, 1930, that I last saw her alive on Oct. 12, 1930, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation
Mitral Insufficency
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) influenza
(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Charles R. Scott M. D.
10/14/, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, ~~Cremation, or Removal~~: Twin Falls Ida
Date of Burial: 10-15 1930.
20. Undertaker: White Mortuary
Address: Twin Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72555

PLACE OF DEATH
County of Twin Falls
City of Falls

Registration District No. 37
Primary Registration District No. 2081

Local Registrar's No. 177

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna Minnie McDrummond

(a) Residence. No. Rimberly St. Dr Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fe	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 1

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
15	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER C. McDrummond
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft Kansas
12. MAIDEN NAME OF MOTHER Eva Yancy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant C McDrummond
(Address) Rimberly

15. Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 5 PM 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct. 11, 1930
that I last saw her alive on Oct 11, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. D. Weaver, M. D.
10/13, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Twin Falls Cemetery	
20. Undertaker L Drake	Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72556

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 176

(No. 1A)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME M. S. Carmen

(a) Residence. No. 5 x th ave West St.
(Usual place of abode)
Length of residence in city or town where death occurred. — yrs. — mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 10

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plumber.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER M. S. Carmen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Zina Hampton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Gladys Carmen
(Address) Council Bluffs Iowa

15. Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 7, 1930
that I last saw h. in alive on Oct 6, 1930
and that death occurred, on the date stated above, at 1-15 a. m.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(duration) — yrs. — mos. 9 ds.
CONTRIBUTORY (Secondary) none
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Unknown
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) C. Russell Heatwole, M. D.
9-7, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Council Bluffs	Oct 9 1930
20. Undertaker	Address
Fred Clarke	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72557

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 175
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Green Berry Esteb

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Beatrice Esteb

6. DATE OF BIRTH (month, day and year) Dec. 6, 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	10	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10. NAME OF FATHER Hardy Esteb
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Louisa Ball
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) North Carolina

14. Informant Lawrence Esteb
(Address) Burley Ida.

15. Filed Oct. 11, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6, 1930, to Oct 10, 1930
that I last saw him alive on Oct 8, 1930
and that death occurred, on the date stated above, at 4:05 P m.
The CAUSE OF DEATH* was as follows:

Cancer of lower jaw

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) J. C. Langenwalter M. D.
Oct 11, 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Elysian Gt	Oct. 13 1930
20. Undertaker W. C. Johnson	Address Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72558

PLACE OF DEATH
County of Twin Falls
City of " "

Registration District No. 37
Primary Registration District No. 2085
(No. R.F.D. # 2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 173

7 11 B

2. FULL NAME Joseph Clem Dean
(a) Residence. No. R F D # 2 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov. 14 1929
7. AGE Years Months 10 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Rancher.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida.

PARENTS
10. NAME OF FATHER Michael Joseph Dean
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Lucy Ellen Dean
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant M. J. Dean
(Address) Twin Falls RFD # 2
15. Filed Oct. 16th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 7th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 7th, 1930
that I last saw him alive on Oct 7th, 1930
and that death occurred, on the date stated above, at 12 midnight
The CAUSE OF DEATH* was as follows:
Influenza-Acute (Gastro-intestinal)
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Toxemia Acute
(duration) yrs. mos. 1 ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only.
(Signed) Duncan L. Alexander, M. D.
Oct 8th, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Oct. 9 1930
20. Undertaker: J. J. Grossman
Address: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72560

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 171

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Richard Womack

(a) Residence. No. Elko Nevada St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 9 / 1903

7. AGE Years 26 Months 11 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Oiler on Diesel
(b) General nature of industry, business, or establishment in which employed (or employer) Engin
(c) Name of employer Mittey Bros

9. BIRTHPLACE (city or town) (State or country) Nevada

PARENTS

10. NAME OF FATHER A L Womack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Sara Womack
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida

14. Informant C A Womack
(Address) Elko Nevada

15. Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1930, to Oct 3rd, 1930 that I last saw him alive on Oct 3rd, 1930 and that death occurred, on the date stated above, at 9 20 a m.

The CAUSE OF DEATH* was as follows:
Burns accidental 1°2°-3° All skin involved Except left shoulder 1 Explosion on Electric Shovel. (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock
..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? Mittey Bros. Camp near Shoshone
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Duncan L Alexander M.D.
Oct 3rd, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Elko Nevada Date of Burial Oct 5 1930

20. Undertaker F E Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72561

PLACE OF DEATH
County Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 170

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Dr Alexander 47

2. FULL NAME Robert Kendall Sluyter

(a) Residence. No. 322 39 N St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 15/1917

7. AGE Years 13 Months 4 Days 18 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hutchison Kansas

PARENTS

10. NAME OF FATHER Ray Sluyter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Rachel Robertson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Ray Sluyter
(Address) Twin Falls

15. Filed Oct. 16, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH 8 00

16. DATE OF DEATH Oct. (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1930, to Oct. 3, 1930, 19
that I last saw him alive on Oct. 3, 1930, 19
and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:
Endo-Myo- & peri carditis.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Dilation heart - acute.

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Twin Falls, Ida.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Xray & Laboratory
(Signed) Duncan L. Alexander M. D.
10/6/30, 19 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Oct 5 1930

20. Undertaker F E Drake
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72562

PLACE OF DEATH
County of Twin Falls
City of Hansen

Registration District No. 37
Primary Registration District No. 2081
Local Registrar's No. 169

Congleton
119

Family home southeast of Hansen
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Corinne Henderson
(a) Residence. No. Southeast of Hansen St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): June 21 1929

7. AGE: One Years, Months: Three, Days: Ten, If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Hansen, Idaho

PARENTS

10. NAME OF FATHER: Edward Henderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Lois Slack
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nebraska

14. Informant: Edward Henderson
(Address) Hansen, Idaho.

15. Filed Oct, 16, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26, 1930, to Oct 1st, 1930
that I last saw her alive on Sept 31th, 1930
and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows: Ileo-Colitis
(duration) yrs. mos. 30 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John H. Congleton, M. D.
10-3, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls cemetery
Date of Burial: Oct 3 1930

20. Undertaker: F.E. Drake
Address: Twin Falls

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72563

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 168

90

2. FULL NAME Anna B. Lewis
(a) Residence. No. 527 39 West St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 26

7. AGE 84 Years — Months — Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Geo F McGuire
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs J. B. Lewis
(Address) Hansen Ida

15. Filed Oct. 12, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 1st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1930, to Oct 1st, 1930
that I last saw her alive on Sept 30th, 1930
and that death occurred, on the date stated above, at 12-15 a.m.
The CAUSE OF DEATH* was as follows:
Cardio Vascular Renal disease
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 21 ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical.
(Signed) H E Lamb, M. D.
Oct 1st, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Oct 3 1930
20. Undertaker F E Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

RECEIVED OCT 27 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72564

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John Nelson Wakley

(a) Residence. No. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ina Wakley.

6. DATE OF BIRTH (month, day and year) Sept. 8 — 1858

7. AGE — Years: 71 — Months: ✓ — Days: 22 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ontario Canada

PARENTS

10. NAME OF FATHER: Nathan W. Wakley
11. BIRTHPLACE OF ~~FATHER~~ (city or town) (State or Country): Ontario Canada
12. MAIDEN NAME OF MOTHER: Eliza Daunt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): New Brunswick, Canada

14. Informant (Address): J. H. Wakley Buhl Ida.

15. Filed 10-1, 1930 — J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 30, to Sept 30 1930, that I last saw him alive on Sept 29, 1930, and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows: Myocarditis, subacute (Several years) Decompensation (4 days)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(duration) several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. L. Burns M. D.
Oct 1, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal: Buhl Idaho — Date of Burial: Oct 3 1930

20. Undertaker: L. Johnson — Address: Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 27 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72565

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lars Dorius Larsen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Eliza Larsen

6. DATE OF BIRTH (month, day and year) Nov. 8-1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	10	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Knute Larsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Dorthea Knaus
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Lewis D. Larsen (Address) Buhl

15. Filed Oct. 1, 1930 J. T. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 30 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29, 1930, to 9-30, 1930
that I last saw him alive on 9-29, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) E. K. Bump, M. D.
10-1, 1930. (Address) Buhl

19. Place of Burial, Cremation, or Removal	Date of Burial
Aberdeen Idaho	10-4 1930
20. Undertaker L. E. Johnson	Address Buhl Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED OCT 27 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72566

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 39
Primary Registration District No. 2087
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME Henry Darby Lorain
(a) Residence. No. Filer Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lorain
6. DATE OF BIRTH (month, day and year) Nov 23 1852
7. AGE Years 77 Months 10 Days 0 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER John Crayton Lorain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Scott Lorain
(Address) Castleford Idaho
15. Filed 9-24, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 23 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1930, to Sept 21, 1930
that I last saw him alive on Sept 21, 1930
and that death occurred, on the date stated above, at 3:10 a.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.
(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) G. A. Dwight, M. D.
Sept 23, 1930 (Address) Filer.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Filer Cemetery
Date of Burial 9/24 1930
20. Undertaker Neville D. Rugg
Address Buhl Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72567

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2-0 17

Local Registrar's No.

(No.) (If death occurred in a hospital or institution give its name instead of street and number.)

4412

2. FULL NAME Elizabeth Jean Herron

(a) Residence. No. Buhl Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20. 1921

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	7	[illegible]	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER John C. Herron.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Grace Appleby
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant Grace M. Herron
(Address) Buhl Idaho

15. Filed 9-9-, 1930 J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-15, 1930, to 9-8, 1930
that I last saw her alive on 9-8, 1930
and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chron. Nephritis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Lab. or clinical

(Signed) Geo Jennings, M. D.
9-8-, 1930 (Address) Buhl Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Buhl Cemetery	9/10/1930
20. Undertaker	Address
Neville & Rupp	Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED OCT 27 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72568

PLACE OF DEATH
County of Twin Falls
City of Buhl

CERTIFICATE OF DEATH
Registration District No. 39
Primary Registration District No. 2077 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lena Caroline Franklin

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C. W. Franklin

6. DATE OF BIRTH (month, day and year) Apr. 5th - 1875

7. AGE: Years 55 Months 4 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Constant Blick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Holland
12. MAIDEN NAME OF MOTHER Minnie Blackman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Holland

14. Informant (Address) J. J. Blick Castleford

15. Filed Sept 6, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Heart Disease
Died unatended following severe illness caused by abdominal growth of several months duration
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) extreme Adposis
10-15 yrs. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) F E Drake Coronor, M. D.
....., 19..... (Address) Twin Falls

19. Place of Burial, Cremation, or Removal: Buhl Ida. Date of Burial: Sept 2 1930

20. Undertaker: L. J. Johnson Address: Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72569

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

101a

2. FULL NAME Lillian Ann Snyder

(a) Residence. No. Buhl St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 17-1929

7. AGE Years 1 Months 4 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Ida

PARENTS
10. NAME OF FATHER Albert Snyder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No Dakota
12. MAIDEN NAME OF MOTHER Mary Kulik
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mum

14. Informant Albert Snyder
(Address) Buhl Idaho

15. Filed 10-27, 1930 J. H. Warfield Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 only Oct 25, 1930
that I last saw her alive on Oct 25, 1930
and that death occurred, on the date stated above, at 5 30 A.m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Respiratory paralysis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A. A. Morrison, M. D.
Oct 27, 1930 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery — Date of Burial Oct 28 1930

20. Undertaker Newville D. Lugg — Address Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE[illegible] NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72570

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

161a

2. FULL NAME Baby Nuchel
(a) Residence. No. Buhl Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 23 1930

7. AGE — Years — Months — Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl Idaho

PARENTS
10. NAME OF FATHER John Nuchel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Elizabeth Hagen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant John Nuchel
(Address) Buhl Idaho

15. Filed 10 24 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 Only Oct 23, 1930
that I last saw her alive on Oct 23, 1930
and that death occurred, on the date stated above, at 7 30 A.m.
The CAUSE OF DEATH* was as follows:
2½ months Premature
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) P. A. Morrison, M. D.
Oct 27, 1930 (Address) Buhl, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery
Date of Burial Oct 24 1930
20. Undertaker Newella D Rugg
Address Buhl Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72571

RECEIVED NOV 12 1930

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clinton Claud LE Tuggy

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Bertha Dora LE Tuggy

6. DATE OF BIRTH (month, day and year): Dec. 1st 1886

7. AGE: Years 43 | Months 10 | Days 14 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Hoover LE Tuggy
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mark Knox
12. MAIDEN NAME OF MOTHER: Bertha Ober
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Mark Knox

14. Informant (Address): Mrs B D LE Tuggy Buhl Ida

15. Filed 10-16, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 15 (Month) (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
10-15, 1930, to 10-15, 1930
that I last saw him alive on 10-15, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.
4 hours (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
1 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Jos Jennings, M. D.
10-16, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal: Buhl Ida. | Date of Burial 19

20. Undertaker: Johnson | Address: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72572

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laura A. Finney
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 6 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. F. Finney

6. DATE OF BIRTH (month, day and year) June 28-1870

7. AGE Years 60 Months 3 Days 13 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Thomas Dix
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Martha Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) Elsie J. Baxter Buhl

15. Filed 10-12, 1930 J. H. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1930, to 11, 1930
that I last saw her alive on Oct 10, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
myelogenous Leukemia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Kansas
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Blood analysis
(Signed) R E Shultz M. D.
Oct 11, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida. Date of Burial 10/14 1930

20. Undertaker L J Johnson Address Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72573

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Woodcock

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of J. M. Woodcock

6. DATE OF BIRTH (month, day and year) Oct 1st 1870

7. AGE Years 60 Months ✓ Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clyde - Ohio

PARENTS
10. NAME OF FATHER John J. Rutherford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Ladusha Hoagland
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New York

14. Informant (Address) J. M. Woodcock Buhl

15. Filed 10-11, 1930 J. H. Wurfley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 26-Sept-, 1930, to 10-Oct-, 1930
that I last saw her alive on 9-Oct, 1930
and that death occurred, on the date stated above, at 11 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Exhaustion

..... (duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Epilepsy
..... (duration) ..... yrs. ..... mos. 15 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Paralysis right side
(Signed) T. W. MacManus, M. D.
11-Oct-, 1930 (Address) Buhl, Idaho

19. Place of Burial, Cremation, or Removal Buhl Ida Date of Burial 10/12 1930

20. Undertaker L. J. Johnson Address Buhl

FORM V. S. No. 5-A—25 M. 1-19 OCT 21 1930

OCT 24 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley - Idaho

City of Near Yellow Pine

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15

Primary Registration District No.

(No. St.)

File No. 72574

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Maples

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1873 (Year)

7. AGE: 57 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Prospector

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Close

(Address)

15. Filed Sep 23 1930 Stella Cain Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 17 (Day) 1930 (Year) 197

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19, that I last saw h alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Homicide
From Gun Shot Wound

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A D Robb Coroner Valley Co M. D.

Sept 18 1930 (Address) Cascade Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Surgeon Bay Wis

DATE OF BURIAL 19

20. UNDERTAKER: A D Robb

ADDRESS: Cascade Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED NOV 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72575

PLACE OF DEATH

County of Valley
City of Deadwood

Registration District No. 15
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME O W Case

(a) Residence. No. 1010 W 4th Ave Spokane Wash
(Usual place of abode)* (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Della J Case

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) ✓

14. Informant C. Y. Garber.
(Address)

15. Filed ..., 19.. Mrs. H. F. Gorton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19.., to ..., 19..
that I last saw h... alive on ..., 19..
and that death occurred, on the date stated above, at ...m.
The CAUSE OF DEATH* was as follows:

...(duration) ...yrs. ...mos. ...ds.
CONTRIBUTORY (Secondary) Heart Failure
...(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A S Robb Coroner
..., 19.. (Address) Cascade Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19

20. Undertaker	Address
A S Robb	Cascade

RECEIVED NOV 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72576

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Valley
City of Rosebery

Registration District No. 15
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME James Franklin Stewart

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: 66 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10 NAME OF FATHER: Robert Stewart
11 BIRTHPLACE OF FATHER (city or town) (State or country): not known
12 MAIDEN NAME OF MOTHER: Landon
13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant
(Address) Elmer Stewart Donnelly Ida.

15 Filed , 19 Mrs. H. P. Jorton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 10 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Oct. 8, 1930, to ~~, 19~~,
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9:30 m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart disease
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] M. D.
10/11, 1930 (Address) McCall Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rosebery Ida
Date of Burial: Oct 12 1930

20. Undertaker: None
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19. OCT 21 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Valley

City of Deadwood Dam Cascade

Registration District No. 15

Primary Registration District No.

(No. ..... St.)

File No. 72577

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Horner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: September (Month) 20 (Day) 1930 (Year)

7. AGE: ..... Yrs. — Mos. — ds.

IF LESS than 1 day how many 3 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cascade, Ida., Deadwood Dam

10. NAME OF FATHER: John Horner

11. BIRTHPLACE OF FATHER (State or Country): Cashville, Mo.

12. MAIDEN NAME OF MOTHER: Dotty Croley

13. BIRTHPLACE OF MOTHER (State or Country): La Harpe, Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs John Horner

(Address) Cascade, Ida., Deadwood Dam

15. Filed ..... 19 .....

Stella Cain
Local Registrar

MEDICAL CERTIFICATE OF DEATH

161a

16. DATE OF DEATH: September (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20 1930, to Sept. 21 1930 that I last saw him alive on Sept 20 1930 and that death occurred on the date stated above, at 1-30 a.M.

The CAUSE OF DEATH* was as follows:

Premature Labor - 6 to 6½ months

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Waldrop M. D.

Oct. 8 1930 (Address) Cascade, Ida., Deadwood Dam

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Cascade, Ida., Deadwood Dam

19. PLACE OF BURIAL OR REMOVAL: Deadwood Dam

DATE OF BURIAL: Sept 21 1930

20. UNDERTAKER: No undertaker Buried by Father, John Horner

ADDRESS: Deadwood Dam

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

RECEIVED NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72578

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

90

2. FULL NAME Samuel H Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Johanna C. Miller

6. DATE OF BIRTH (month, day and year) Sept 27 - 1859

7. AGE Years 70 Months 10 Days 21 If LESS than 1 day ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Belfast Ireland

PARENTS
10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Johanna C Miller
(Address) Weiser Idaho

15. Filed Oct 24, 1930. W. R. Hamilton Registrar
MHM

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to Aug 18, 1930
that I last saw him alive on Aug. 15, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Aortic Insufficiency
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Hypostatic Pulmonary Congestion (duration) ..... yrs. ..... mos. 4 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical.
(Signed) Ernesto Fimmey, M. D.
8-20, 1930 (Address) Weiser, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 8-20-1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72579

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 16

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Graham

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Stephen Graham

6. DATE OF BIRTH (month, day and year) April 9.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Edward Hartley

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Watson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant Mrs Dallas McFarr
(Address) Weiser Ida

15. Filed Oct 15, 1930 W. P. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7, 1929, to June 15, 1930
that I last saw her alive on June 15, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Senility.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Paralysis of heart.
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F A Schmutz, M. D.
Oct 6, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sunset Cemetery	10-7 1930
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72580

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Rachel Perkins

(a) Residence. No. Weiser Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Whr
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Hyrum Perkins

6. DATE OF BIRTH (month, day and year) Apr. 4 - 1850

7. AGE Years 80 Months 5 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Frank Jennings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane Jeffries
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Bertha J. McCord
(Address) Weiser Idaho

15. Filed Oct 15, 1930 W. R. Hamilton M.H.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Sep 27, 1930
that I last saw her alive on July 3rd, 1930
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows:
Myocarditis & Senility
(duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Acute Dilatation
Cardiac (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phys. Ex.
(Signed) Frank Jennings, M. D.
Sep. 27, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Boker Oregon — Date of Burial 9-28-1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RE... NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72581

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 14

164

2. FULL NAME Nicholas H Coots

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Whr
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Coots

6. DATE OF BIRTH (month, day and year) Sept. 19 – 1849

7. AGE 80 Years | Months 11 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10. NAME OF FATHER John Coots
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas.
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Robert F Coots
(Address) Weiser Ida

15. Filed Oct. 14, 1930 W. R. Hamilton M.H.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5/30, 19..., to Sept 6th, 1930
that I last saw him alive on Sept 6th/30, 19...
and that death occurred, on the date stated above, at 11:30 a m.
The CAUSE OF DEATH* was as follows:
Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? –
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) C. C. Conant, M. D.
9/7/30, 19... (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Manns Creek | Date of Burial 9-8-1930

20. Undertaker L. C. Northam | Address Weiser Ida

RECEIVED NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72583

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 12

2. FULL NAME Helen Steele

(a) Residence. No. Sunnyside St. 117
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 13 - 1913

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	0	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Arthur Steele
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Edgmar Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Arthur Steele
(Address) Weiser - Idaho

15. Filed Oct. 13, 1930 W. R. Hamilton M. H. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20, 1930, to Sept. 26, 1930
that I last saw h[illegible] alive on Sept. 26., 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Gangrene & Septic Poisoning

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) appendicitis
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept. 27 30
no
Was there an autopsy?
What test confirmed diagnosis? —

(Signed) Wm Marshall, M. D.
Sept 27 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	9-28 1930
20. Undertaker L. C. Northam	Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72584

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112

Local Registrar's No. 11

(No.) 57
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bobbie Maxeine Browne

(a) Residence. No. Mormon Creek St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 13 - 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Jacksonville
(State or country) Oregon

PARENTS

10. NAME OF FATHER Leslie Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mattie Sanders

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Leslie Browne
(Address) Weiser Ida

15. Filed Oct. 13, 1930 W. R. Hamilton Registrar
M.H.M.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1930, to Aug. 23, 1930
that I last saw her alive on Aug 23, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. M. Marshall M. D.
Aug 23, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	8-27-1930

20. Undertaker	Address
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. RECEIVED NOV 12 1930 Registration District No.

County of Primary Registration District No.

City of (No. , St.)

File No. 72585

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Hoef Kelso

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August 21 1877 (Month) (Day) (Year)

7. AGE: Yrs. 53 Mos. 2 ds. 14

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER: Charles Kelso

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER: Martha Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nettie Kelso
(Address) Cambridge, Idaho.

15. Filed 11-10-30. 191....

DR. R. T. WHITEMAN CAMBRIDGE, IDAHO

...rar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 5 1930, to Oct. 10 1930, that I last saw him alive on Oct. 10 1930, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH was as follows*:
Acute Intestinal Obstruction

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Post-operative Complications
Paralytic Ileus.
(Duration) yrs. mos. ds.

(Signed) R. T. Whiteman M. D.
19.... (Address) Cambridge - Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: Nov 7 1930

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SOBS. 24854

RECEIVED NOV 20 1930

72586

DO NOT WRITE IN THIS SPACE
State File No. 72586

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Adams
City of Council

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Harris

(a) Residence. No. Weiser Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Petra Harris

6. DATE OF BIRTH (month, day and year) Mar 7 - 1888

7. AGE Years	Months	Days	If LESS than 1 day,
42	8	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weiser Idaho

PARENTS

10. NAME OF FATHER Frank Harris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pleasanville California
12. MAIDEN NAME OF MOTHER Nettie Oakes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vernon Co. Wis.

14. Informant Mrs Nettie Harris
(Address) Weiser. Idaho

15. Filed Nov. 20, 1930 Bessie N Lepper State Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11th, 1930, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:
Auto accident Car going off the road he was killed instantly, accidental
(duration) yrs. mos. ds.
~~CONTRIBUTORY~~ (Secondary) his neck was broken in the wreck
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Robt. P. Young ~~M. D.~~
11-18, 1930 (Address) Council Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	11-15-1930

20. Undertaker	Address
L. C. Northam	Weiser. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

72587

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72587

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 101

PLACE OF DEATH

County of Ada
City of Boise
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME TAYLOR, Benjamin Z. 90

(a) Residence. No. ..... St. Fruitland, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. B.Z. Taylor

6. DATE OF BIRTH (month, day and year) Dec. 24, 1847

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	10	18	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fruit grower & farmer
(b) General nature of industry, business, or establishment in which employed (or employer) xx
(c) Name of employer xx

9. BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) xx
(State or Country)

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) xx
(State or Country)

14. Informant L.H. Beaman
(Address) U.S.V.B., Boise, Idaho

15. Filed 11-19, 1930 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Aug. 26, 1930, to Nov. 15, 1930
that I last saw him alive on Nov. 15, 1930
and that death occurred, on the date stated above, at 11.30 p. m.
The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Lobular pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) F.O. SMITH, Reg. Med. Officer, M. D.
Nov. 17, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov. 18 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

72588

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72588

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 294
(No. 1608 Leadville St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs. Clara M. Wilkinson

(a) Residence. No. 1608 Leadville St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of L. J. Wilkinson

6. DATE OF BIRTH (month, day and year) March 7th 1858

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ----mm.----
72	8	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sycamore, Illinois.

PARENTS

10. NAME OF FATHER A. A. Holcomb.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Jane Anne Goodsell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant Mrs. Alcorn.
(Address) Nampa, Idaho.

15. Filed 11-19, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 17th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1930 to Nov 17 1930 that I last saw her alive on Nov 12 1930 and that death occurred, on the date stated above, at 4a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Brights Disease and Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Jas Burke M. D.
11/17/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Kohlerlawn, Nampa, Ida. Date of Burial 11/19/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

72589

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72589

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 102

PLACE OF DEATH

County of Ada
City of Boise
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME LONGLEY, Charles L.

(a) Residence. No. U.S.Assay Office St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Carolyn Longley

6. DATE OF BIRTH (month, day and year) 5-27-1843

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	5	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Assay work
(b) General nature of industry, business, or establishment in which employed (or employer) xx
(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10. NAME OF FATHER xx

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant L.H.Beaman
(Address) U.S.V.B., Boise, Idaho

15. Filed 11-24, 1930 W. V. Rhodes Registrar
R.D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930, to Nov. 21, 1930
that I last saw him alive on Nov. 21, 1930
and that death occurred, on the date stated above, at 9.30 p.m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) General Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) F. C. SMITH, Reg. Med. Officer, M. D.
Nov. 22, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	11-24-30 19
20. Undertaker	Address
White Mortuary	Twin Falls, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72590
72590

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 300
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

146 E

2. FULL NAME William Clinton Ward.

(a) Residence. No. 1210 Colorado St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Ward.

6. DATE OF BIRTH (month, day and year) August 25th 1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Houseman
(b) General nature of industry, business, or establishment in which employed (or employer) Bristol Hotel.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Wm. C. Ward.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Mary E. Sloan.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pa.

14. Informant Mrs. Elizabeth Ward.
(Address) Boise, Idaho.

15. Filed 12-2, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 26th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ ~~and that~~ death occurred, on the date stated above, at 9 P.M. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Coroner's Jury Verdict:-By being struck by an Automobile driven by Keith Seaman and that said accident was unavoidable.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? None.

(Signed) W. McBratney Coroner, M. D.
11/29/30 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11/30/30 19
20. Undertaker: Wm. McBratney.	Address: Boise, Idaho.

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 1 1930

72591

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72591

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 57

101a

2. FULL NAME Bogo Crljen (Crljen)
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Crljen

6. DATE OF BIRTH (month, day and year): 1873-12-25

7. AGE: Years 57, Months 2, Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: B. H. Sgo

9. BIRTHPLACE (city or town) (State or country): Jugo Slovonia

PARENTS
10. NAME OF FATHER: Nick Crljen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Jugo Slovonia
12. MAIDEN NAME OF MOTHER: Eva Marech
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Jugo Slovonia

14. Informant: Steve Crljen
(Address): Kellogg Ida

15. Filed 11-5, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 7, 1930
that I last saw him alive on Oct 7, 1930
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
lobar pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) T. W. Larawa, M. D.
11-4, 1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida — Date of Burial: Oct 11 1930

20. Undertaker: R. L. Stout — Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

725-92 V

DO NOT WRITE IN THIS SPACE
State File No. 72592

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

Local Registrar's No. 104

(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

66

2. FULL NAME GILL, Earl W.

(a) Residence. No. Bristol Hotel St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mrs. Rosa Gill

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	4	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) XX

(c) Name of employer XX

9. BIRTHPLACE (city or town) (State or country) Californnia

PARENTS

10. NAME OF FATHER XX

11. BIRTHPLACE OF FATHER (city or town) (State or Country) XX

12. MAIDEN NAME OF MOTHER XX

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XX

14. Informant L.H. Beaman

(Address) U.S.V.B., Boise, Idaho

15. Filed 11-28-30 W.H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to November 25, 1930

that I last saw him alive on November 25, 1930

and that death occurred, on the date stated above, at 3.20 p. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage gastric (following excessive alcoholic intoxication)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy grand mal with deterioration; Gastric ulcer.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F.C. SMITH, Reg. Med. Officer, M. D.

Nov. 26, 1930 (Address) U.S.V.B., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov. 28, 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

72593

DO NOT WRITE IN THIS SPACE
State File No. 72593

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 304
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Cecil Hull

(a) Residence. No. 417 Ave. C. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bessie Hull.

6. DATE OF BIRTH (month, day and year) September 8th 1891

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mechanist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montpelier, Idaho.

PARENTS

10. NAME OF FATHER William Hull.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) London, England.

12. MAIDEN NAME OF MOTHER Mary E. Bailey.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) Mrs. Bessie Hull. Boise, Idaho.

15. Filed 12-1, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 28, 1930
that I last saw him alive on Nov 28, 1930
and that death occurred, on the date stated above, at 9:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Colon - (Sigmoid)
(duration) yrs. 1½ mos. ds.
CONTRIBUTORY (Secondary) Intestinal Obstruction
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Nov 21 1930
Was there an autopsy? No
What test confirmed diagnosis? Autopsy
(Signed) W. A. Forbes, M. D.
11/29/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11/30/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

725-94

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72594

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 106
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. FULL NAME MOORE, Samuel W.

(a) Residence. No. Soldiers' Home St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of XX

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	11	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) XX
(c) Name of employer XX

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER XX
11. BIRTHPLACE OF FATHER (city or town) (State or Country) XX
12. MAIDEN NAME OF MOTHER XX
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) XX

14. Informant L.H. Beaman
(Address) U.S.V.B., Boise, Idaho

15. Filed 12-1, 1930 W.N. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 18, 1930, to Nov. 27, 1930
that I last saw him alive on Nov. 26, 1930
and that death occurred, on the date stated above, at 2.45 a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma, adenomatous rectum & post vesical space with metastises, general.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) V.H.D. Mitral Insufficiency & Pyocarditis, chr.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an ~~autopsy~~? no
What test confirmed diagnosis? clinical

(Signed) F. C. SMITH, Reg. Med. Officer, M. D.
Nov. 28, 1930 19 (Address) ~~U.S.V.B., Boise, Ida.~~

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov. 29, 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1930

72595

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72595

PLACE OF DEATH
County of Jefferson
City of Roberts

Registration District No. 98
Primary Registration District No. 2176
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

A2

2. FULL NAME Lloyd B. Dodge
(a) Residence. No. Roberts Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Lake Dodge
6. DATE OF BIRTH (month, day and year) Apr 25, 1897
7. AGE Years 33 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ucon Idaho

PARENTS
10. NAME OF FATHER Frank M. Dodge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sheridan County New York
12. MAIDEN NAME OF MOTHER ? Monroe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ?

14. Informant Guy A. Dodge
(Address)

15. Filed 12-1, 1930 C. A. Garin Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Drowning
Accidental
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Earl D. Jones M. D.
Dec 4, 1930 (Address) Roberts Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls
Date of Burial 19
20. Undertaker J. A. Wood
Address Idaho Falls

RECEIVED NOV 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72596

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Ada

City of Boise, Idaho

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Louis Lawson

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	American	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 2, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Weiser, Idaho (State or country)

PARENTS

10. NAME OF FATHER Charles Lewis Lawson

11. BIRTHPLACE OF FATHER (city or town) Tracy, Minn (State or Country)

12. MAIDEN NAME OF MOTHER Clara Sias

13. BIRTHPLACE OF MOTHER (city or town) Weiser, Idaho (State or County)

14. Informant .....
(Address) Box 27 Weiser, Idaho

15. Filed ....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 28, 1930, to October 29, 1930
that I last saw him alive on October 29, 1930
and that death occurred, on the date stated above, at 11:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Jaundice

(duration) from birth mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Clinical and lab. findings

(Signed) Harmon G. Krenkel M. D.
10-30, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Weiser, Idaho	Oct. 30, 1930
20. Undertaker L. C. Northam	Address Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72597

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 293
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Doris Irene Bollinger.
(a) Residence. No. 6 Miles South West of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

143a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 12.1903.

7. AGE Years 27 Months 3 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carterville Missouri.

PARENTS
10. NAME OF FATHER James Campbell.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Abie Brown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) Mrs. N.W. Lowman. Boise, Idaho. R?D. # 2.

15. Filed 11-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 17, 1930
that I last saw her alive on Nov 16, 1930
and that death occurred, on the date stated above, at 3 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis from abortion by pills self administered about 20 day before. Pregnant 2 months.
(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? Yes Date of Nov 12 1930
Was there an autopsy? No -
What test confirmed diagnosis? Drainage of abdomen
(Signed) W. A. Foelsch, M. D.
11/17, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial Nov.18.30.
20. Undertaker Summers & Krebs. Address Boise, Ida.

Budge

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72598

RECEIVED DEC 8 1930

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 292
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Viola Robbins Thorn

(a) Residence. No. 405 S. 4th St. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

46

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of John S Thorn

6. DATE OF BIRTH (month, day and year) March 22-1858

7. AGE Years 72 Months 7 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meadsville Pa

PARENTS
10. NAME OF FATHER Jra W. Robbins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Maryan Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) John S Thorn 405 S. 4 St Boise Idaho

15. Filed 11-14, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 13, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 13, 1930
that I last saw her alive on Nov 13, 1930
and that death occurred, on the date stated above, at 10 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) Alfred Budge Jr. M. D.
Nov 14, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial Nov 15 1930

20. Undertaker Seemmers & Krebs Address Boise Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72599

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1904
Local Registrar's No. 291
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edith Rhea

(a) Residence. No. 518 N 8th St.
(Usual place of abode.)
Length of residence in city or town where death occured. 2 yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank A Rhea

6. DATE OF BIRTH (month, day and year) Dec 3 - 1885

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	11	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER William Hottenstein
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Ella Fields
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) Frank A Rhea 518 N 8th St Boise Idaho

15. Filed 11-14, 1930 W. F. Rhea Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 - 28 to Nov 13 1930
that I last saw h..... alive on Nov 13 1930
and that death occurred, on the date stated above, at 6:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Metastatic Carcinoma of left lung.

(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of Cervix
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Boise Idaho
Did an operation precede death? No Date of Oct 2 1930
Was there an autopsy? No
What test confirmed diagnosis? Microscopic Laboratory
(Signed) James R Stewart M. D.
Nov 14, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	Nov 15 1930
Undertaker	Address
Summers & Reed	Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Lane

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72600

PLACE OF DEATH
County of Ida
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes)
Local Registrar's No. 290

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nettie Hylton 41
(a) Residence. No. St. Council Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of G. B. Hylton

6. DATE OF BIRTH (month, day and year) Feb 15-1891

7. AGE Years 39 Months 8 Days 25 If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER Grant Burgin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo
12. MAIDEN NAME OF MOTHER Wallace
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓ ✓

14. Informant (Address) G. B. Hylton Council Ida

15. Filed 11-12, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 10, 1930 (Month) (Day) 19... (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-5-30, 19..., to 11-10-30, 19...
that I last saw her alive on 11/10/30, 19...
and that death occurred, on the date stated above, at 6 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Traumatic infection (Staphylococcic) right fore-arm and hand. (Septicemia)
(duration) yrs. mos. 11 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Council, Idaho
Did an operation precede death? yes Date of 11/8/30
Was there an autopsy? no
What test confirmed diagnosis? Surgery & Bacteriology
(Signed) Ernest E. [illegible] M. D.
11/12/, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal New Plymouth
Date of Burial Nov 12. 1930

20. Undertaker J. H. Adair
Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72601

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1904
Local Registrar's No. 289
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John B. Stewart

(a) Residence. No. 175 St. Glenns Ferry Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gladys Stewart

6. DATE OF BIRTH (month, day and year) Aug 27-1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	2	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Meat Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Benjamin Utah

PARENTS
10. NAME OF FATHER Franklin Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Harriet Guell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant (Address) Mrs John B Stewart Glenns Ferry Idaho

15. Filed 11-11, 1930 W. E. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1930, to Nov. 10th, 1930
that I last saw him alive on Nov. 10th, 1930
and that death occurred, on the date stated above, at 8:50 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mesenteric Thrombosis, Acute -

17 hours (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute food poisoning
10 or 12 hours (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy
(Signed) C. M. Taylor M. D.
Nov. 10th, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Creek Cemetery — Date of Burial: Nov. 13 1930
20. Undertaker: Summers & Rich — Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

REGISTERED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72602

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ada
City of Boise.
Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 288
(No. St Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy Baker.

(a) Residence. No. 1515. Grove Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March. 6. 1861.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portland Michigan.

PARENTS

10. NAME OF FATHER John Pilkinton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant (Address) Claude. M. Baker. 1515. Grove St. Boise, Idaho.

15. Filed 11-10, 1930 Wm. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/3, 1930 to 11/8, 1930
that I last saw her alive on 11/8, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder.
+ Pelvic Organs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Not Stated

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) Fred A Turnipseed M.D
11/10, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Nov. 10. 193
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72603

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1094
Local Registrar's No. 287
(No.) Idaho Soldiers Home Hospital.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James R. Watson
(a) Residence. No. Soldiers Home St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 9 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1849

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Veteran of Indian Wars
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) E. G. Burnett Idaho Soldiers Home

15. Filed ..., 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 6 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan 1, 1930, to ..., 19...
that I last saw him alive on Aug. 6, 1930
and that death occurred, on the date stated above, at ...m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility - Myocardiac degeneration -

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Typical Syndrome
(Signed) Fred H Patterson M. D.
11/7, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Nov 8 1930
20. Undertaker: Summers & Rich — Address: Boise Ida

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 12004

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 206
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

179

2. FULL NAME Fay Louise Johnson.

(a) Residence. No. 1710. N. 16 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September. 26.1928.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
2	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Clifford. F. Johnson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska.
12. MAIDEN NAME OF MOTHER Rilla Bullard.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Emmett, Idaho.

14. Informant Clifford. F. Johnson.
(Address) 1710. N. 16 Street, Boise, Ida.

15. Filed 11-6, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 5 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 4, 1930, to November 5, 1930, that I last saw her alive on November 5, 1930, and that death occurred, on the date stated above, at 7 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hot water burn from falling in wash tub of hot water.
70% skin surface burned 2nd degree

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. A. Forsch, M. D.
11-6, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Nov. 6.30.
20. Undertaker: Summers & Krebs. — Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72605

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 285
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME George Tew
(a) Residence. No. 437 South 9th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 17-1844

7. AGE Years 86 Months 6 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London, England

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Louis Klein

15. Filed 11-5, 1930 Boise W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Oct 31, 1930
that I last saw him alive on Oct 31, 1930
and that death occurred, on the date stated above, at 1 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular
renal Disease (duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Boise, (Home)
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) Gerald F. Nokes M. D.
Nov. 3, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation or Removal Morris Hill Cemetery Date of Burial 11 14 1930

20. Undertaker Schreiber & McCann Address Boise

Nokes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

Dr. Stewart

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72606

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004
Local Registrar's No. 284
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME LeRoy Carl McConnel
(a) Residence. No. Montour, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. — yrs. — mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single
6. DATE OF BIRTH (month, day and year) Jan. 21, 1917
7. AGE Years 13 Months 10 Days 11 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS
10. NAME OF FATHER Roy C. McConnel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Caldwell, Idaho.
12. MAIDEN NAME OF MOTHER Alma Carlson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denver, Colo.

14. Informant (Address) Mrs. Roy C. McConnel Montour, Idaho.

15. Filed 11/3/30, 19.... ~~Boise~~, W. H. Pl... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November, 2nd. 1930, 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 2, 1930
that I last saw him alive on Nov 1, 1930
and that death occurred, on the date stated above, at 10:00 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Intersusception of Ileum
(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Montour Ida
Did an operation precede death? Yes Date of Oct 31, 30
Was there an autopsy? No
What test confirmed diagnosis? Physical findings
(Signed) James L. Stewart, M. D.
11/3/30, 19.... (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Morris Hill cemetery
Date of Burial 11/3/30 19

20. Undertaker William McBratney
Address Boise, Ida.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72607

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
(No. St. Lukes Hospital)
Local Registrar's No. 205

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dora Belle Hansen

(a) Residence. No. Emmett, Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occured. — yrs. — mos. 2 ds. How long in U. S if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Fem	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Hansen

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42.			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grangeville Idaho

PARENTS

10. NAME OF FATHER Edward Heath

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Susan Kirk

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Texas

14. Informant (Address) Joe Hansen Emmett Idaho

15. Filed 11-3, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 30 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from Oct 29, 1930, to Oct 30, 1930 that I last saw h.. alive on Oct 30 at, 1930 and that death occurred, on the date stated above, at 4 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Contusion of brain from automobile injury with diffuse hemorrhage

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? yes.
What test confirmed diagnosis? autopsy

(Signed) J A Springer, M. D.
Nov 3rd, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 11/2 1930

20. Undertaker: E W McBratney — Address: Boise Idaho

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72608

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2005
Local Registrar's No. 103
(No. 127)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Murray

(a) Residence. No. ... St. Franklin District
(Usual place of abode.)
Length of residence in city or town where death occured. ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Murray

6. DATE OF BIRTH (month, day and year) July 20 or 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	4	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Timber Cruiser
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich.

PARENTS

10. NAME OF FATHER Murray
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Merle Murray (Address) Boise Ida

15. Filed Nov 26, 1930 W. F. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930 to Nov 23, 1930 Nov 23, 1930
that I last saw h... alive on ... and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver
(Primary)
with ascites
(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Boise Ida
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) James L. Stewart, M. D.
11/26, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 11/26 1930
20. Undertaker: Schubert McCann — Address: Boise

L. Stewart.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72609

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 100
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Newton Limbarger

(a) Residence. No. 5 Miles S. W of Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Erma Limbarger

6. DATE OF BIRTH (month, day and year) Feb 6 1849.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	9	8.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS

10. NAME OF FATHER Franklin Limbarger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Mary Moore
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant Mrs. R N. Limbarger
(Address) Boise Idaho R # 4

15. Filed 11-17, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4th, 1930, to Nov. 14th, 1930,
that I last saw h.im alive on Nov. 14th, 1930
and that death occurred, on the date stated above, at 12:25 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? only history

(Signed) C. M. Taylor M. D.
Nov 17th, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery — Date of Burial Nov. 17 1930

20. Undertaker Summers & Krebs — Address Boise Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECE[illegible] DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72610

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 99
(No. Franklin Dist Near Boise
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George William Riggs 90
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lavina B Riggs

6. DATE OF BIRTH (month, day and year) Feb 21 - ~~1930~~ 1858

7. AGE Years 72 Months 8 Days 15 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Vancouver Wash.

PARENTS

10. NAME OF FATHER Andrew Riggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Ellen Durgan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Lulu M. Neuland Boise Ida

15. Filed [illegible], 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Nov, 1930
that I last saw him alive on Nov 3, 1930
and that death occurred, on the date stated above, at 7.45 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) 5 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Coronary thrombosis
(duration) yrs. mos. 10 min

18. Where was disease contracted if not at place of death? Weiser Idaho
Did an operation precede death? No Date of —
Was there an autopsy? — No
What test confirmed diagnosis? None
(Signed) T. M. Brastan, M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal: Morris Hill
Date of Burial: Nov 9 1930
20. Undertaker: Schreiber & McCann
Address: Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72611

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 98

PLACE OF DEATH

County of Ada
City of Boise
(No. U. S. Veterans' Bureau, Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

34

2. FULL NAME Rex P. Averett

(a) Residence. No. Emmett, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ Mrs. Clara Averett

6. DATE OF BIRTH (month, day and year) Sept. 16, 1889

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Utah
(State or country)

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) —
(State or Country)

14. Informant H. Bock
(Address) U.S.V.B., Boise, Idaho

15. Filed 11-8, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 6, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
December 9, 1929, to November 6, 1930
that I last saw him alive on November 6, 1930
and that death occurred, on the date stated above, at 8:20 a. m.
The CAUSE OF DEATH* was as follows:
Respiratory failure (primary)
Cerebral lues (secondary)

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral lues
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) F. D. SMITH, M. D.
Nov. 7, 1930 (Address) Reg. Med. Off. U.S.V.B., Boise, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett, Idaho	Nov. 9 1930
20. Undertaker	Address
Buckman Undertaking Parlor	Emmett, Ida

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72612

PLACE OF DEATH
County of Ada
City of
Registration District No. 8 4
Primary Registration District No. 2004
Local Registrar's No. 97
(No.)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Agnes Mary Silliman Silliman 112

(a) Residence. No. 7 Miles West of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sam. C. Silliman

6. DATE OF BIRTH (month, day and year) July. 5.1890.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	4	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Indian Valley, Idaho.
(State or country)

PARENTS
10. NAME OF FATHER John Ivers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Marie O Higney.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland,

14. Informant Sam. C. Silliman
(Address) R.D.#. 2. Boise, Idaho.

15. Filed 11-6 30 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 6, 1930, that I last saw her alive on Nov 2, 1930, and that death occurred, on the date stated above, at 2 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Gastritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. Callaway Joslin, M. D.
11-6, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Nov. 9.1930
20. Undertaker: Summers & Kreps Address: Morris Hill Cemetery Boise, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 8 1930

DO NOT WRITE IN THIS SPACE
State File No. 72613

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 96
(No. Maple Grove School House)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace L. Doores 90

(a) Residence. No. Ranch, near Maple Grove School St.
(Usual place of abode.)
Length of residence in city or town where death occured 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	W	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Dewey Doores

6. DATE OF BIRTH (month, day and year) Nov. 17- 1898

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	11	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burlington, Colo.

PARENTS

10. NAME OF FATHER L.D. Amy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known.
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ?

14. Informant Mr. Dewey Doores
(Address) Boise, Idaho

15. Filed 11-3, 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10/ 22/ 30, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 22, 1930, to Oct 22, 1930
that I last saw h.. alive on Oct 22, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremia Regurgitation
(duration) 5 yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) O.H. Parker, M. D.
Oct 24, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 10/ 26/30 19
20. Undertaker: Wm. McBratney — Address: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72614

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 299
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Frank Page.
(a) Residence. No. 1420 Washington St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Flora Page.

6. DATE OF BIRTH (month, day and year) March 29th 1851

7. AGE Years 79 Months 7 Days 22 If LESS than 1 day, ---- hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Addison, Main.

PARENTS
10. NAME OF FATHER Joseph Page.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Boston, Mass.
12. MAIDEN NAME OF MOTHER Julia Tibbetts.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mass.

14. Informant (Address) Miss Thelma Page. Boise, Idaho.

15. Filed 11-24, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 21st 1930, 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930 to Nov 22, 1930
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) General Arteriosclerosis
(duration) 5 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James L. Stewart M. D.
11/24/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 11/23/30 19
20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72616

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1604
(No. St Alphonsus)
Local Registrar's No. 297
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME James Roland Vest

(a) Residence No. New Plymouth Ida St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. *If married, widowed, or divorced*
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	2	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Plymouth Ida

PARENTS

10. NAME OF FATHER James Vest
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Shelby Neb.
12. MAIDEN NAME OF MOTHER Mamie Williams
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Logan Utah

14. Informant (Address) James Leslie Vest. New Plymouth Idaho.

15. Filed 11-24, 1930 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 23 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930, to Nov. 23, 1930, that I last saw him alive on Nov. 22, 1930, and that death occurred, on the date stated above, at 2:10 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hypertrophic pyloric stenosis.
Known (duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Vitamin B deficiency ins
mother's diet (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home.
Did an operation precede death? Yes. Date of Nov. 22'30
Was there an autopsy? Yes
What test confirmed diagnosis? Pathological findings
(Signed) Harmon A. Greenlaw, M. D.
Nov. 24, 1930 (Address) Boise.

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Cemetry Emmett	11-25 1930
20. Undertaker	Address
Schreiber & McCann	Boise Ida

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72617

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 296
(No. St Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Margaret Bolte.

(a) Residence. No. 414. Washington Street. St. Portland, Oregon.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: L.W. Bolte.

6. DATE OF BIRTH (month, day and year): May. 4. 1887.

7. AGE: Years 43. Months 6. Days 18. If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sidney Nebraska.

PARENTS

10. NAME OF FATHER: Edward Mc Lernon.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown.

14. Informant (Address): L.W. Bolte. 414. Washington St, Boise, Idaho.

15. Filed 11-24. 1930 W. H. Rice Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930, to Nov 22, 1930, that I last saw h.. alive on Nov 11, 1930, and that death occurred, on the date stated above, at 1 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Heart leakage

(duration) 40 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? Congenital
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) G. L. Kinnie, M. D.
11/22 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal: Denver Colorado. Date of Burial: Nov. 25. 1930.
20. Undertaker: Summers & Krebs. Boise, Idaho. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

RECEIVED DEC 8 1930 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72618

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004 Local Registrar's No. 295

(No. 1204 Hays Street)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Charles E. Wright.

(a) Residence. No. 1204 Hays Street. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susan Wright.

6. DATE OF BIRTH (month, day and year) January 15th 1864

7. AGE Years	Months	Days	If LESS than 1 day, ~~hrs. or~~ min.
66	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Newspaperman, Editor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moine, Iowa.

PARENTS

10. NAME OF FATHER James A. Wright.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Caroline Johnson.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant Mrs. Susan Wright.
(Address) Boise, Idaho.

15. Filed 11-21, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 19th 1930, (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~, 19~~ ~~, to~~ ~~, 19~~ ~~that I last saw him alive on~~ ~~, 19~~ about 2 A.M. ~~and that~~ death occurred, on the date stated above, at 2 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH was as follows:

Acute Heart Attack.

Found Dead in Bed.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Heart Disease.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No Inquest Held.

Did an operation precede death? No. Date of

Was there an autopsy? No.

~~What test confirmed diagnosis?~~ Wm. McBratney

(Signed) Coroner of Ada Co., ~~M. D.~~

11/19/30, 19 (Address) Boise, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11-21-30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72619

Registration District No. 84
Primary Registration District No. 2161
Local Registrar's No. 19

1004

PLACE OF DEATH

County of Bannock
City of Grace

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charlotte D Hawkins

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) August 24 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
		1	21	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Grace, Idaho
(State or country)

PARENTS

10. NAME OF FATHER Alvin Hawkins

11. BIRTHPLACE OF FATHER (city or town) Grace
(State or Country) Idaho ~~Utah~~

12. MAIDEN NAME OF MOTHER Winnifred Sharp

13. BIRTHPLACE OF MOTHER (city or town) Inter
(State or Country) Ida.

14. Informant J. N. Grahame
(Address) Kelley, Idaho

15. Filed Dec 1, 1930 Mrs. G. G Fist
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to Oct 21, 1930
that I last saw h... alive on ....., 19.....
and that death occurred, on the date stated above, at 5:00 a. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY Immature
(Secondary)
(duration) ~~Wks.~~ 2 mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Russell Isgett, M. D.
Oct 22, 1930 (Address) Lava Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lava Idaho	Oct. 22 1930
20. Undertaker	Address

FORM V. S. No. 5-25 M. 1-19

RECEIVED DEC 3 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12627
Registered No. 193

1. PLACE OF DEATH

Registration District No. 84
Primary Registration District No. 2161

County of Bannock
City of Mc Cammon (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Brown McCarty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6. DATE OF BIRTH July (Month) 27 (Day) 1876 (Year)

7. AGE 64 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Salt Lake County Utah

10. NAME OF FATHER Joseph Brown

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Jane Humble

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah C. Watts

(Address) Mc Cammon Ida.

15.

Filed ..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1930, to Oct 17 1930, that I last saw her alive on Oct 16 1930, and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Mediastinal tumor (probably Carcinoma) pressing on Heart

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) None known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

10-17 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72623

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5947
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

181a

2. FULL NAME Clarence A. Walton

(a) Residence. No. North of Pocatello City St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Husband of Hazel Fenwick

6. DATE OF BIRTH (month, day and year) April 23, 1907.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	7	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wyoming

PARENTS

10. NAME OF FATHER Clarence A. Walton

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ethel Coziah

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois

14. Informant Mrs. Clarence A. Walton
(Address) North of Pocatello City

15. Filed 11/28/30. 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 19.., to Nov 25, 19..
that I last saw him alive on Nov 24, 19..
and that death occurred, on the date stated above, at 11 30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. W. Crothers M. D
11/26/30., 19.... (Address) Poca., Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. Date of Burial: 11/28/30. 19

20. Undertaker: Arthur W. Hall Mortuary Address: Poca. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72624

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5946
(No. Pocatello General Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jenkin T. Davis 102
(a) Residence. No. Robin - Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of ~~the~~ WIFE of Mrs. Annie J. Davis

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
43	9	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Robin Idaho.

PARENTS

10. NAME OF FATHER Jenkin Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tonypandy South-Wales
12. MAIDEN NAME OF MOTHER Mary Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tonypandy South-Wales

14. Informant Mr. Heber Edwards
(Address) 128 N. Harrison

15. Filed 11/26, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 23 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1930, to Nov 23 1930,
that I last saw him alive on Nov 23 1930
and that death occurred, on the date stated above, at 10:55 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Congestion both lungs
following operation

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Pneumonia Staph
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? Pocatello
Did an operation precede death? Yes Date of 11/20/30
Was there an autopsy? Yes
What test confirmed diagnosis? Usual
(Signed) H. C. Dawson, M. D.
11/25, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Rolem Ida	11/27 1930
20. Undertaker H. L. McHan	Address 217 South

Dr. H. C. Dawson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DEC 3 1930

DO NOT WRITE IN THIS SPACE
State File No. 72625

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161 Local Registrar's No. 5945

(No. Pocatello General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. **FULL NAME** Melba B. Caldwell

(a) Residence. No. Holbrook, St. Idaho

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November, 16, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello Idaho

PARENTS

10. NAME OF FATHER E.E. Caldwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Dorothy E. Carter

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant Mr. E.E. Caldwell
(Address) Holbrook, Idaho

15. Filed 11/19/1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month), 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-16, 1930 to 11-19, 1930

that I last saw h— alive on 11-19, 1930

and that death occurred, on the date stated above, at 1.30 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature birth 7th mo.-
Labor came on after mother
rode 100 miles in auto over
rough road.-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D C Ray M. D.

11-19, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Snowville, Utah	Nov. 20, 1930

20. Undertaker Arthur Hall Mortuary Address Poca; Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72626

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5944
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

42

2. **FULL NAME** Elizabeth Priest

(a) Residence. No. 207 North Grant Ave. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John Priest

6. DATE OF BIRTH (month, day and year) March, 19, 1861

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	8	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Thomas S. Hewitt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Booth

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant Mrs. Mary Ann Edgley
(Address)

15. Filed 11/20/1930, 19.... Registrar. J. P. Young

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month), 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1930, to Nov. 19, 1930, that I last saw her alive on 11-19, 1930 and that death occurred, on the date stated above, at 12:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 11-13-30
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) D. C. Kay, M. D.
11-19, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cem. Poca. Id.	11/21/30 19
20. Undertaker	**Address**
Arthur W. Hall	Pocatello. Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72627

PLACE OF DEATH

County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5943
(No. 640 North 11th. Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

40

2. FULL NAME Leonard Melvin Burnapp
(a) Residence. No. 640 North 11th. Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July, 11, 1930

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
0	4	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pocatello, Idaho

PARENTS

10. NAME OF FATHER: Walter K. Burnapp
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oregon
12. MAIDEN NAME OF MOTHER: Louise Lawrence
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Pocatello, Idaho

14. Informant (Address): Walter K. Burnapp, 640 North 11th Ave., Poca., Idaho

15. Filed 11/20/30, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November, 19, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 19, 1930
that I last saw him alive on Nov 19, 1930
and that death occurred, on the date stated above, at 3 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Convulsive
Seizure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
11/20, 1930 (Address)

19. Place of Burial, Cremation, or Removal: Pocatello, Idaho
Date of Burial: 11/21/30 19

20. Undertaker: Arthur W. Hall
Address: Poca., Idaho

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72628

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5942
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Jane Evelyn Oliver
(a) Residence. No. 546 North Lincoln St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Seth H. Oliver

6. DATE OF BIRTH (month, day and year) Aug-27-1867

7. AGE Years 63 Months 3 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oregon - City Oregon.

PARENTS
10. NAME OF FATHER Wm Marfitt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Juliet E. Warsham
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Frankford Kentucky

14. Informant (Address) Mr. E. W. Oliver 546 N. Lincoln Ave.

15. Filed Nov 19, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 18, 1930
that I last saw her alive on Nov 18, 1930
and that death occurred, on the date stated above, at 8 40 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature] M. D.
11/19/, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Ontario Oregon
Date of Burial 19

20. Undertaker H. L. McHan
Address 217 So. Arth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72629

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5941
(No. 358 North 13th. Ave. Poca., Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Beatrice Helen Smith 90
(a) Residence. No. 358 North 13th. Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife of James H. Smith

6. DATE OF BIRTH (month, day and year): Sept. 26, 1903.

7. AGE: Years 27 | Months 1 | Days 21 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Dubois, Idaho.

PARENTS

10. NAME OF FATHER: Henry Rassmansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Agnes Buhl
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Germany

14. Informant (Address): James H. Smith, 358 North 13th. Ave. Poca., Ida.

15. Filed 11/17/30, 19.. J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 16, (Day) 1930. (Year), 19..

17. I HEREBY CERTIFY, That I attended deceased from I saw her 19.., to ....., 19..
that I last saw h..... alive on at death, 19..
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pachymeningitis Lethargica
5 years
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Cerebral ~~Bulbar~~ Paralysis sudden
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Hesting + Previous
(Signed) Physician O. F. Call, M. D.
11/17/30., 19.. (Address) Poca., Ida.

19. Place of Burial, Cremation, or Removal: Dubois, Idaho. Date of Burial: 11/19/30 19

20. Undertaker: Arthur W. Hall Address: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72630

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5940
(No. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME William Kelly
(a) Residence. No. 141 So - 9th St. St. X
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widower
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower.
6. DATE OF BIRTH (month, day and year): March 25-1841
7. AGE: Years 89, Months 7, Days 15. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Iseman England

PARENTS
10. NAME OF FATHER: Wm Kelly.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England.
12. MAIDEN NAME OF MOTHER: Margaret Cowan.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown.

14. Informant (Address): Mr. L. H. Brown. 141 So - 9th St.
15. Filed 11/15, 1930. J. H. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 15 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11/15, 1930, to 11/15, 1930
that I last saw him alive on 11/15, 1930
and that death occurred, on the date stated above, at ..... m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: General Senility
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Carcinoma of Tongue
..... (duration) 1 yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature], M. D.
11/15, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery
Date of Burial: Nov. 1930
20. Undertaker: H. L. McHan.
Address: 217 So. Arts

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72632

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5938
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME Cleta Jeanene Clawson

(a) Residence. No. 215 Taft Avenue St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January 28, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	9	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10. NAME OF FATHER George C. Clawson

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Ethel Viola Jensen

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Wyoming

14. Informant George C. Clawson
(Address) Pocatello, Idaho

15. Filed 11/13/30. 19 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 11, 1930
that I last saw her alive on Nov 11, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gastro-Intestinal
Intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam

(Signed) O. L. Powell, M. D.
11/13, 1930 (Address) O. L. Powell

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain View Cemetery	Nov., 13, 1930
20. Undertaker	Address
Arthur W. Hall Mortuary	Poca. Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12653

PLACE OF DEATH
County of Bannock
City of McCammon
Registration District No. 28
Primary Registration District No. 216 Local Registrar's No. 5937
(No. McCammon, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Erasto Roblez

(a) Residence. No. McCammon, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Mexican	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs, or ....min.
	26			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Section Hand
(b) General nature of industry, business, or establishment in which employed (or employer) O. S. L. R. R.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Rafael Dias McCammon, Idaho.

15. Filed 11/18/30. 19.... Register.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Exact date unknown
Between the 1st. & 8th. of Nov., 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found dead in pasture at McCammon
November 9, 1930.
Myocarditis
.....(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (Secondary) Exposure
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes, Nov. 11, 1930.
What test confirmed diagnosis? Post Mortem
(Signed) Arthur W. Hall Coroner, M. D.
11/18/30. 19.... (Address) Poca., Ida.

19. Place of Burial, Cremation, or Removal: Mountain View Cemetery Pocatello, Idaho. — Date of Burial 19

20. Undertaker Arthur W. Hall Mortuary — Address Pocatello Idaho.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12654

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 53
Primary Registration District No.
Local Registrar's No. 153

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Ezra Allred

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Libbie Wallentine

6. DATE OF BIRTH (month, day and year): Oct 25, 1880

7. AGE: Years 50 | Months 0 | Days 8 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Paris Idaho

PARENTS

10. NAME OF FATHER: Marvin Allred
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Council Bluffs Iowa
12. MAIDEN NAME OF MOTHER: Wanda Bird
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Springville Utah

14. Informant
(Address)

15. Filed Nov. 4th 1930 Mrs. J. D. Skinner Registrar
Per Mrs. A. Hess.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 3 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 26, 1930 to November 3, 1930
that I last saw alive on November 3, 1930
and that death occurred, on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH* was as follows: Coma following a left sided hemiplegia.
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Embolism from Endocarditis Rheumatic
(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis? Paralysis of left arm, leg and lower left face about 12 years ago. Rheumatism
(Signed) [illegible] M. D.
Nov 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho — Date of Burial: Nov. 6 1930

20. Undertaker: Dan Price Jr. — Address: Paris Idaho Logan Utah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72635

Registration District No. 53
Primary Registration District No.
(No.)
Local Registrar's No. 154

204

PLACE OF DEATH
County of Bear Lake
City of Paris

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Molen

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Simpson Molen
6. DATE OF BIRTH (month, day and year): April 13, 1837
7. AGE: Years 93 | Months 6 | Days 26 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sunderland England.

PARENTS
10. NAME OF FATHER: James Collings
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sunderland England
12. MAIDEN NAME OF MOTHER: Elizabeth Bewick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant
(Address)

15. Filed Nov. 10th 1930 Mrs. J. S. Stinger Registrar
Per Mrs. A. Hess.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19
that I last saw her alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH was as follows: Died without any Warning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? No diagnosis Made
(Signed) Spence & Lynch M. D.
Nov. 10, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Paris Idaho. Date of Burial: Nov. 10 1930
20. Undertaker: Dan Price Address: Paris Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12656

Registration District No. 53
Primary Registration District No.
Local Registrar's No. 153

(No. 119B)

PLACE OF DEATH
County of Bear Lake
City of Paris

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Collings Jr.

(a) Residence No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Rich Collings

6. DATE OF BIRTH (month, day and year) January 3, 1845

7. AGE	Years	Months	Days	If LESS than 1 day,
	85	10	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kent England

PARENTS

10. NAME OF FATHER James Collings Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sunderland England
12. MAIDEN NAME OF MOTHER Elizabeth Bewick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sunderland England

14. Informant Mrs. L. Collings
(Address) Paris Idaho

15. Filed Nov. 22nd, 1930. Mrs. J. B. Skinner Registrar
Per. Mrs. A. Hess

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~January~~ November 21 1930
(Month) (Day) (Year)

17. ~~I HEREBY CERTIFY~~, That I attended deceased from October 28, 1930 to November 21, 1930
that I last saw him alive on November 21, 1930
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Intestinal Obstruction (High first partial later Complete.)
(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Constant vomiting Vomiting of fecal matter Inability to get food to remain
(Signed) J. E. Greer, M. D.
November 22, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paris Idaho	November 24 1930
20. Undertaker Dan Price	Address Paris Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72637

PLACE OF DEATH
County of Bear Lake
City of Liberty

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 156

205-B

2. FULL NAME Susanna Clark King
(a) Residence. No. Liberty Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David M. King

6. DATE OF BIRTH (month, day and year) Dec 17, 1840

7. AGE Years 89 Months 11 Days 12 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Thomas B. Clark
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Ann Shooker
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant X G. A. Smith
(Address) Liberty Idaho

15. Filed Dec. 2nd, 1930 Mrs. J. S. Skinner Per Dr. C. O. Moore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—
that I last saw h— alive on —, 19—
and that death occurred, on the date stated above, at 5.20 P. m.
The CAUSE OF DEATH* was as follows:
Cause Unknown but Natural. No Doctor attending
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C O Moore, M. D.
12/1, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Liberty, Idaho — Date of Burial: Dec. 2nd 1930

20. Undertaker: T. L. Austin — Address: Liberty Ida.

FORM V. S. No. 5-12 M. 6-15-17. RECEIVED DEC 5 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 72638
Registered No. 15

1. PLACE OF DEATH
County of Benewah
City of De Smet
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Robert M. Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH. Nov (Month) 16 (Day) 1860 (Year)

7. AGE 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Robert Thomas Sr.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Josina Titus

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard M. Thomas
(Address) Farmington Wash.

15. Filed Nov. 17 1930 John Post Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 16 (Month) (Day) 1930 (Year) 131

17. I HEREBY CERTIFY, That I attended deceased from Aug 1930 to Nov 1930 that I last saw him alive on Sept 1930 and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:
Uraemia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Enlarged Prostate
.....(Duration) 2 Yrs. ..... mos. ..... ds.
(Signed) Dr. C B Cliger M. D.
11-16 1930 (Address) Tekoa Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? .....
Former or usual residence Farmington Wash RFD

19. PLACE OF BURIAL OR REMOVAL Farmington Wash
DATE OF BURIAL 11-18 1930

20. UNDERTAKER C. L. Schuelerud
ADDRESS Tekoa Wash

FORM V. S. No. 5 RECEIVED DEC 5 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah.

City of DeSmet,

Registration District No. 31

Primary Registration District No.

(No. ..... St.)

File No. 72639

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Dubey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male ~~Single~~

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov, 2nd, 1930 (Month) (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tekoa, Wash.

10. NAME OF FATHER: George Dubey

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Allice Sirois

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Dubey

(Address) DeSmet, Idaho.

15. Filed Nov. 22 1930 John Post Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov, 22nd. 1930 (Month) (Day) 19 (Year) 162

17. I HEREBY CERTIFY, That I attended deceased from Nov, 2nd 1930 to Nov, 22 1930 that I last saw h. in alive on Nov. 12, 1930 and that death occurred on the date stated above, at 11A.M.

The CAUSE OF DEATH* was as follows:

Impotency of foramen ovale.

..... (Duration) ..... Yrs. ..... mos. 19 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Clyne M. D.

11/22/30 (Address) Tekoa Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 7 days

Where was disease contracted if not at place of death? Congenital

Former or usual residence DeSmet, Idaho.

19. PLACE OF BURIAL OR REMOVAL: DeSmet, Idaho — DATE OF BURIAL: Nov. 23 1930

20. UNDERTAKER: Henry Klattenberg — ADDRESS: DeSmet, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12040

Local Registrar's No. 174

PLACE OF DEATH

County of Bannock

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Bertha Jane Halverson

(a) Residence. No. Blackfoot R.F.D. 2 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of F. O. Halverson

6. DATE OF BIRTH (month, day and year) April 9 1893

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	7	18	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah Ogden

PARENTS

10. NAME OF FATHER John W Butler

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah

12. MAIDEN NAME OF MOTHER Sarah Jane Dance

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant O. B. Halverson

(Address) Blackfoot R F D 2

15. Filed Nov. 28, 1930 Mo Valent E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930, to Nov 27, 1930, that I last saw h[er] alive on Nov 27, 1930, and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Symptoms & Physical Examination

(Signed) M. E. Egan M. D.

Nov 28 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Ogden Utah — Date of Burial: 19

20. Undertaker: E J Peck — Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72642

Local Registrar's No. 172

Registration District No. 121
Primary Registration District No. 1987

PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. 6 Judson St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Charlotta Jane Ferguson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 8 1842

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	7	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Tennessee

PARENTS

10. NAME OF FATHER Daniel Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant E. F. Armstrong Jr.
(Address) Blackfoot Idaho

15. Filed Nov. 28, 1930 M. Hale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Nov. 26, 1930, that I last saw her alive on Nov. 26, 1930, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of June 1-1929
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. W. Mitchell, M. D.
Nov. 26, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Groveland cemetery — Date of Burial: Nov 28 1930

20. Undertaker: E. J. Peck — Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72643

PLACE OF DEATH
County of Bingham
City of Shelly

Registration District No. 121
Primary Registration District No. 2194
(No.) Local Registrar's No. 171
(If death occurred in a hospital or institution, give its name instead of street and number.)

88a

2. FULL NAME Lawrence A Quigg
(a) Residence. No. Shelly Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word). Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct. 20 1909
7. AGE Years 21 Months 1 Days 4 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Clarinda Iowa

PARENTS
10. NAME OF FATHER A. C. Quigg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Ola E. Gibson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Blanchard Iowa

14. Informant A. E. Quigg
(Address) Shelly Ida.
15. Filed Dec 24, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 24 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Nov. 24, 1930
that I last saw him alive on 11-23- 1930
and that death occurred, on the date stated above, at 12 30 P m.
The CAUSE OF DEATH* was as follows:
Chronic Endo + Myocarditis
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 10 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Edwin Cutter, M. D.
11/26/ 1930 (Address) Shelley Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida. Date of Burial Nov. 26 1930
20. Undertaker V. F. McHan Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72644

PLACE OF DEATH
County of BINGHAM
City of BLACKFOOT
Registration District No. 1-1
Primary Registration District No. 2144
Local Registrar's No. 170
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** BENJAMIN S BROWN

(a) Residence. No. ... St. Caldwell
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ... yrs. ... mos. 30 ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

76

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 17 1838

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
92				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Benjamin Brown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Hockings

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant (Address) Thomas Carson, Attendant Blackfoot, Idaho.

15. Filed No. 2d, 1930 Jo McHaleu E Estes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 23, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1930, 19..., to Nov 23-1930, 19..., that I last saw him alive on Nov 23,1930, 19..., and that death occurred, on the date stated above, at 9:30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

GENERAL PARALYSIS

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) Geo Williams, M. D.
Nov 28th 1930, 19... (Address) Blackfoot, Ida

19. Place of Burial, ~~Cremation,~~ or Removal: Iowa. Date of Burial: 11-28-30 19

20. Undertaker: Modern Mortuary, Address: Blackfoot.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 12615

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bingham
City of Shelley.

Registration District No. 1-1
Primary Registration District No. 1-174
Local Registrar's No. 151
(No.) 1000
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** David Staples

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Susana Staples

6. DATE OF BIRTH (month, day and year) Oct. 24-1867

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	0	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) day labor
(c) Name of employer Many

9. BIRTHPLACE (city or town) (State or country) Corinne Utah

PARENTS

10. NAME OF FATHER Henry Staples
11. BIRTHPLACE OF FATHER (city or town) (State or Country) London England
12. MAIDEN NAME OF MOTHER Mary Godfrey
13. BIRTHPLACE OF MOTHER (city or town) Ludley England

14. Informant Willis Hansen
(Address) Shelley Idaho

15. Filed Dec 5 1930 W. Wilderson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22 1930, to Nov. 23 1930
that I last saw him alive on Nov. 23 1930
and that death occurred, on the date stated above, at 10 20 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) T. W. Speer M. D.
Nov 24 1930 (Address) Shelley Ida

19. Place of Burial, Cremation, or Removal Jack A. Wood Goshen Ida. Date of Burial Nov 26 1930
20. Undertaker Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Bingham
City of Shelley Idaho

Registration District No. 121
Primary Registration District No. 2144
Local Registrar's No. [illegible]
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alice M. Andrews

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James Andrews

6. DATE OF BIRTH (month, day and year)

7. AGE Years 69 Months 1 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Manchester Jowa

PARENTS
10. NAME OF FATHER To James McBride
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Elizabeth Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County) .....

14. Informant (Address) Ida M Little Shelley Idaho

15. Filed Nov. 28, 1930 Mrs Pauline E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 21st, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Was dead, to when, 19..... that I last saw in ..... alive on ..... 19..... and that death occurred, on the date stated above, at 6 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: I believe it to be apoplexy.

..... (duration) Sudden ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. W. Roberts M. D.
Nov. 21, 1931 (Address) Shelley Ida

19. Place of Burial, Cremation, or ~~Removal~~ Shelley, Idaho — Date of Burial Nov 28 1930

20. Undertaker Jack A. Wood — Address Idaho Falls, Idaho

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72647

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No.)
Local Registrar's No. 167

129

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rebecca Ann Weigel

(a) Residence. No. 690 W Bridge St.
(Usual place of abode)
Length of residence in city or town where death occurred. 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 15 - 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68	11	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines Iowa

PARENTS

10. NAME OF FATHER Granville Hendricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Compton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant J M Weigel
(Address) Blackfoot Ida

15. Filed Nov. 21, 1930 Mrs Hallie E. Catron Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1930 to Nov 20 1930
that I last saw her alive on Nov 14 1930
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) J O Hampton M.
11-20 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Riverside Thomas Cem.	Nov 23 1930

20. Undertaker E J Peck — Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72648

CERTIFICATE OF DEATH

PLACE OF DEATH

County of BINGHAM
City of BLACKFOOT

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 166
(No. SOUTH IDAHO INSANE ASYLUM)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME MARY HUBER

(a) Residence. No. ..... St. Caldwell, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE
4. COLOR OR RACE: WHITE
5. Single, Married, Widowed, or Divorced (write the word.): Divorced

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Unknown

6. DATE OF BIRTH (month, day and year)

7. AGE: 56 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County): "

14. Informant (Address): Minnie Hayes, Att. Blackfoot, Ida.

15. Filed Nov. 19, 1930. Mrs Helen E. Patrick, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 18th, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1st 1927, 19..., to Nov 18, 1930, 19...
that I last saw her alive on Nov 18, 1930, 19...
and that death occurred, on the date stated above, at 3:40P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cancer of Uterus and intestines

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

..... (duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Geo. Williams, M. D.
Nov 18, 1930 (Address) Blackfoot Ida

19. Place of Burial, Cremation, or Removal: Asylum Cemetary
Date of Burial: Nov 19 1930

20. Undertaker: Marion Clark
Address: Blackfoot

Grave no 66.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72649

PLACE OF DEATH
County of Bingham
City of Shelley, Ida

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 168

2. FULL NAME Annie M. Chapman

133

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Arthur Chapman

6. DATE OF BIRTH (month, day and year) Sept. 17, 1880

7. AGE: Years 50 Months 2 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): ✓
(c) Name of employer: ✓

9. BIRTHPLACE (city or town) (State or country): Salt Lake City Utah

PARENTS
10. NAME OF FATHER: Alex Hamilton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dublin Ireland
12. MAIDEN NAME OF MOTHER: Marguerite E. Gordon
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake City Utah.

14. Informant: Arthur Chapman
(Address) Shelley Idaho

15. Filed Nov. 19, 1930 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov., 1929, to Nov 18, 1930
that I last saw her alive on Nov 17, 1930
and that death occurred, on the date stated above, at 12 00 a.m.
The CAUSE OF DEATH* was as follows: Gall stones
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Carcinoma of Liver
..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes Date of Nov. 26-29
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) F. E. Roberts, M. D.
Nov. 18, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Shelley Idaho — Date of Burial: Nov. 20 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72650

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 127
Primary Registration District No. 8194

Local Registrar's No. 164

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1016

2. FULL NAME Edward Pepper

(a) Residence. No. Blackfoot, Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Shuf. herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Payson Utah

PARENTS

10. NAME OF FATHER Charles Pepper
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Helen Adelia Webb
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Ray Pepper
(Address) Blackfoot

15. Filed Nov. 17, 1930 Mrs. Helen E. Louie Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 16, 1930, that I last saw him alive on Nov 16, 1930, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Findings

(Signed) W W Beck, M. D.
11/17, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or Removal	Date of Burial 19
Payson Utah	
20. Undertaker E J Funk	Address Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72651

PLACE OF DEATH
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 163

100 a

2. FULL NAME Shirley Gene Wheeler
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 22nd 1930

7. AGE Years | Months | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Idaho

PARENTS
10. NAME OF FATHER W N Wheeler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bushnell Ill.
12. MAIDEN NAME OF MOTHER Mads Martin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rockville Utah

14. Informant W N Wheeler
(Address) Blackfoot Idaho

15. Filed Nov. 17, 1930. Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Nov. 16, 1930, to ....., 19..., that I last saw her alive on Nov 16, 1930 and that death occurred, on the date stated above, at 8 p. m.,
The CAUSE OF DEATH* was as follows:
acute Bronchio pneumonia
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? physical finding
(Signed) J. O. Humphrey M. D.
11-16, 1930 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Green City Cemetery | Date of Burial Nov 17 1930

20. Undertaker E. F. Peck | Address Blackfoot

MARGIN RESERVED FOR BINDING

...ITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

...item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS ...ate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-...N is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72652

PLACE OF DEATH
County of Bingham
City of Pingree

Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

162

2. FULL NAME Lenora Atwood.
(a) Residence. No. Pingree, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 12, 1930

7. AGE Years Months 4 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pingree, Idaho

PARENTS
10. NAME OF FATHER Ivan J. Atwood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Lenora Boyd
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky

14. Informant Ivan J. Atwood
(Address) Pingree Idaho

15. Filed Mr. 14, 1930 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) — 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on 11-13, 1930, to ....., 19....
that I last saw her alive on 11-13, 1930
and that death occurred, on the date stated above, at 3:30 p.m.
The CAUSE OF DEATH* was as follows:
Marasmus
Intestinal Influenza
..... (duration) ..... yrs. 4 mos. ..... ds.
CONTRIBUTORY (Secondary) Valv. disease Heart - Mitral
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) J. O. Hampton M. D.
11-14, 1930 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ L.C. Cem. Blackfoot acting
Date of Burial Mr. 15 1930

20. Undertaker Sarah Cammack
Address Pingree Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72653

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
(No.)
Local Registrar's No. 167

(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Eldora Landon

(a) Residence. No. 7th St. Shelley Idaho
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis Landon

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 31 | Months 10 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Nevada

PARENTS

10. NAME OF FATHER: Jennis Martinsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Sarah Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah.

14. Informant: Francis Landon
(Address) Shelley Ida RFD #1

15. Filed Nov. 6, 1930 Mrs Nalen E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930 to Nov 2, 1930
that I last saw her alive on Nov. 1 1930
and that death occurred, on the date stated above, at 4:30 a.m.
The CAUSE OF DEATH* was as follows: Interstitial nephritis

(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. W. Roberts, M. D.
Nov 4, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Basalt Cemetery — Date of Burial: Nov 5. 1930
20. Undertaker: Jack F. Wood — Address: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72654

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 160

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Olive Lillian Broadbent

(a) Residence. No. North Maple St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: J. H. Broadbent

6. DATE OF BIRTH (month, day and year): March 29, 1860

7. AGE: Years 70, Months 7, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Oregon Wis.

PARENTS

10. NAME OF FATHER: Lyman L. Pastle

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Annia Lee

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: J H Broadbent
(Address) Blackfoot Idaho

15. Filed Nov. 3, 1930 Mrs Walter E. Patrick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 2, 1930 that I last saw her alive on Oct 30, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) — yrs. — mos. 10 ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W W Beck, M. D.

Nov 3, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem.
Date of Burial: Nov. 4, 1930

20. Undertaker: E.T.Peck
Address: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72655

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 36

2. FULL NAME Micheal Bannett

(a) Residence. No. ..... St. ..... wright
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 25. 1850

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Madison Indiana

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant H C Schwamb
(Address) Hailey Ida.

15. Filed 11-30, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 19, 1930
that I last saw him alive on Nov 19, 1930
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Anasarca
..... (duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
11/30, 1930 (Address) E. W. [illegible] Hailey, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Hailey
Date of Burial: Nov 2 1930

20. Undertaker: Hanna & Amos F.
Address: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72656

Local Registrar's No. 35

PLACE OF DEATH
County of Blaine
City of Picabo

Registration District No. 57
Primary Registration District No. 2022
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lilian Scharlet Smith

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of X

6. DATE OF BIRTH (month, day and year) Jan 1 - 1916

7. AGE	Years	Months	Days	If LESS than 1 day,
	14	10	15	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Wisdom Idaho

PARENTS

10. NAME OF FATHER C. H. Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Milwaukee Wisconsin

12. MAIDEN NAME OF MOTHER Lilian Reed

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ridgeway Wisconsin

14. Informant C. H. Smith
(Address) Picabo Idaho

15. Filed 12-1, 1930 Robert H. Wright Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930, to Nov 16, 1930
that I last saw her alive on Nov 16, 1930
and that death occurred, on the date stated above, at 8 P. m.
The CAUSE OF DEATH* was as follows:
Burn covering over 2/3 body area - Accidental
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E W [illegible], M. D.
12/1, 1930 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Picabo Ida	Nov 19 1930
20. Undertaker	**Address**
Harris & Conroe	Hailey

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12057

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
Local Registrar's No. 18
(No. Priest Lake)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Samuel T Byars

(a) Residence. No. Coolin Id. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Grace Byars

6. DATE OF BIRTH (month, day and year) January 23 18

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Summer resort owner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self

9. BIRTHPLACE (city or town) (State or country) Tenn

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo Tennessee

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Grace Byars
(Address) Priest River

15. Filed Nov. 19, 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ 19 to 19
~~that I last saw h alive on~~ 19
~~and that~~ death occurred, on the date stated above, at about 4 P m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease, History of spells of unconsciousness verified by reliable witnesses
(duration) mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd G. Wendle, M. D.
Nov. 18, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River	Nov 19 1930
20. Undertaker Turnbull Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1930
REGISTERED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72658

PLACE OF DEATH
County of Bonner — Registration District No. 85
City of Priest River — Primary Registration District No. 2185
(No. Priest River Hospital)
Local Registrar's No. 17
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Lawrence Edward Ulbright

(a) Residence. No. ..... St. Spokane, Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fannie Ulbright

6 DATE OF BIRTH (month, day and year) Oct. 6, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	0	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spokane, Wash.

PARENTS

10 NAME OF FATHER Otto Ulbright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany ~~Unknown~~

12 MAIDEN NAME OF MOTHER Phoebe M. Cline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Mrs. H. L. Johnson
(Address) Coolin, Ida.

15 Filed Nov. 3, 1930 H. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. (Month) 3 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov. 3rd, 1930, to Nov. 3, 1930,
that I last saw him alive on Nov 3rd, 1930
and that death occurred, on the date stated above, at 2:00 A. m.

The CAUSE OF DEATH* was as follows:
Shot wound (accidental)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov. 3, 1930
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. J. Stauffer, M. D.
Nov. 3, 1930 (Address) Priest River Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane, Wash	
20. Undertaker	Address
Hennessey & Calloway	Spokane Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72655

PLACE OF DEATH

County of Banner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 92
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Carlsen

(a) Residence. No. Selle Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Carlsen

6. DATE OF BIRTH (month, day and year) Sept 17 1870

7. AGE Years	Months	Days	If LESS than 1 day,
60	2	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS

10. NAME OF FATHER Charles Kjellen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland unobtainable
12. MAIDEN NAME OF MOTHER Finland unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Mrs Mary Carlsen
(Address) Selle Idaho

15. Filed Nov 29, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 27 (Day) 1930 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from on ....., 19....., to Nov 17, 1930
that I last saw him alive on Nov. 17, 1930
and that death occurred, on the date stated above, at 2:45 P m.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchial asthma
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Floyd L. Wendle M. D.
12-29, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Nov 30 1930

20. Undertaker	Address
Turnbull Co	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1930

PLACE OF DEATH

County of Bonner

City of Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 78

Primary Registration District No. 2155

(No. Ponderay Hotel)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72660

Local Registrar's No. 91

164

2. FULL NAME Julia Selle

(a) Residence. No. ..... St. Selle Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 56 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Selle

6. DATE OF BIRTH (month, day and year) March 27, 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82	7	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10. NAME OF FATHER Miller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Martha Loughlin
(Address) Sandpoint, Idaho.

15. Filed Nov 28, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Several years, 19.., to Nov 28, 1930
that I last saw her alive on Nov 28, 1930
and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

(1) Senility
(2) Chronic nephritis - Uremia 3 yrs

(duration) Several yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) Several yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) C. V. Stackhouse, M. D.

Nov. 28, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Nov. 28 1930

20. Undertaker	Address
L. G. MOON	Sandpoint, Idaho.

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72661

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

Local Registrar's No. 90

(No. 805 N. 6th Ave)

(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Charles Albert Snyder

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Celia Snyder

6. DATE OF BIRTH (month, day and year) August 17, 1878

7. AGE	Years	Months	Days	If LESS than 1 day,
	52	3	2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Terra Haute
(State or country) Indiana

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) Unknown
(State or Country)

14. Informant Edward Snyder
(Address) Sandpoint Ida

15. Filed Nov 20, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 19. 1930
(Month) (Day) (Year) 19...

17. I HEREBY CERTIFY, That I attended deceased from Oct 6, 1930, to Nov 14, 1930
that I last saw him alive on Nov 14, 1930
and that death occurred, on the date stated above, at 3:30 A. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no. Date of .....
Was there an autopsy? no.
What test confirmed diagnosis? Clinical

(Signed) R S Cross, M. D.
Nov 19, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cmetery	Nov. 20, 1930

20. Undertaker L. B. Moon — Address Sandpoint Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72662

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 76
Primary Registration District No. 2155
Local Registrar's No. 89
(No. Humbird Lbr Camp #3)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1880

2. FULL NAME Howard Louis Blum

(a) Residence. No. Selle St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 8 1910

7. AGE Years	Months	Days	If LESS than 1 day,
20	8	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Humbird Lbr Co

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Charles Blum
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Lydia Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Chas Blum
(Address) Selle Idaho

15. Filed Nov 21, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 19 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 3 P. M. m.
The CAUSE OF DEATH* was as follows:
Accidental Traumatism: Struck by falling tree.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. B. Shoop Coroner
Nov. 21, 1930 (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Nov 22 1930

20. Undertaker	Address
Turnbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72663

PLACE OF DEATH

County of Bonner
City of Morton
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 88
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Grant Morton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Morton

6. DATE OF BIRTH (month, day and year) Oct. 4, 1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	1	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Westfield Wisconsin

PARENTS

10. NAME OF FATHER William Vance Morton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bangor Maine
12. MAIDEN NAME OF MOTHER Julia Crowell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant Mrs. Emma Morton
(Address) Morton, Idaho.

15. Filed Nov 16, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 14, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1930, to Oct, 1930, that I last saw h[illegible] alive on Oct, 1930, and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart disease
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Floyd A. Beardsle M. D.
Nov. 15, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Seneacquoteen Cemetery	Nov. 16 1930

20. Undertaker	Address
L. GL Moon	Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72664

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 67

(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Horace Alvin Tromblee

(a) Residence. No. Sandpoint, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Tromblee

6. DATE OF BIRTH (month, day and year) November 11, 1881

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49		2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer) Logging Railroad

(c) Name of employer Humbird Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Loyal Wisconsin

PARENTS

10. NAME OF FATHER William Henry Tromblee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Lydia Churchill

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Loyal Wisconsin

14. Informant Mrs. Kate Tromblee
(Address) Sandpoint, Idaho.

15. Filed Nov 14, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Nov. 13, 1930
that I last saw h. sis alive on Nov 13, 1930
and that death occurred, on the date stated above, at 5:17 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) Wm Fy Tyler, M. D.
Nov 14, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Nov. 15 1930

20. Undertaker	Address
L. G. Moon	Sandpoint Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72665

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 86

2. FULL NAME Albert Artman

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~ Edna Artman

6. DATE OF BIRTH (month, day and year) March 29, 1888.

7. AGE Years 42 Months 7 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Car Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) Railroad
(c) Name of employer Great Northern Railway Co.

9. BIRTHPLACE (city or town) Little Falls
(State or country) Minn

PARENTS
10. NAME OF FATHER August Artman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Lucy Washbush
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Edna Artman
(Address) Spokane, Washington

15. Filed Nov 13, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 10, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended, deceased from Saw him only to at death, 19..
that I last saw h..... alive on ....., 19..
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) acute dilatation of heart Instantaneous death.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Manner of death.
(Signed) F. B. Evans, M. D.
Nov. 12, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane, Washington. Date of Burial 19

20. Undertaker L. G. Moon Address Sandpoint, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72666

PLACE OF DEATH

County of Bonner
City of Eagle
Registration District No. 78
Primary Registration District No. 2158
Local Registrar's No. #5
(No.) 44
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Ernest Lombard

(a) Residence. No. Eagle Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 9 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	9	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Ernest Lombard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maine
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Fred Lombard
(Address) Eagle Ida

15. Filed Nov 10, 1930. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Nov 9, 1930
that I last saw him alive on Nov 5, 1930
and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical

(Signed) Wm F Tyler, M. D.
Nov 10, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Westmond	Nov 11 1930
20. Undertaker	Address
Trumbull Co	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72667

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
(No. 410 S. First Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No. 84

74a

2. FULL NAME Lavina Jane Sears
(a) Residence. No. 410 S. First Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of D. T. Sears

6. DATE OF BIRTH (month, day and year) March 13, 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Platteville
(State or country) Wisconsin

PARENTS

10. NAME OF FATHER Samuel Woodburn
11. BIRTHPLACE OF FATHER (city or town) Fairview
(State or Country) Ohio
12. MAIDEN NAME OF MOTHER Matilda Moore
13. BIRTHPLACE OF MOTHER (city or town) Trumble
(State or Country) Ohio

14. Informant M. W. Foster
(Address) Sandpoint, Idaho.

15. Filed Nov. 10, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 8th, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1930 to Nov. 8, 1930
that I last saw h.er alive on Nov. 6, 1930
and that death occurred, on the date stated above, at 6:00 p.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 16 ds.
CONTRIBUTORY (Secondary) accidental fracture left femur
(duration) yrs. 7 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) Wm F. Tyler, M. D.
Nov 10, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Nov. 11, 1930
20. Undertaker	**Address**
L. G. Moon	Sandpoint, Idaho.

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72665

PLACE OF DEATH

County of Bonner
City of Sandpoint
Registration District No. 76
Primary Registration District No. 2155
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

2. FULL NAME Mrs Rosie Cochran

(a) Residence. No. Samuels St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	m

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 13 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65 ~~65~~			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Barton Hollingworth

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER unclaimable

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant R B Cochran
(Address) Seattle Wn

15. Filed Nov 10, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1930, to Nov 7, 1930, that I last saw her alive on Nov 7, 1930 and that death occurred, on the date stated above, at 10 21 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O F Page, M. D.

Nov 7, 1930 (Address) Sandpoint Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	11/10 1930
20. Undertaker Funeral Co	Address Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED DEC 9 1930

PLACE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72669

County of Bonner
City of Sandpoint
Registration District No. 16
Primary Registration District No. 2155
Local Registrar's No. 82
(No. Pannell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edward Haley 119

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) unobtainable

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Edward Haley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unobtainable
12. MAIDEN NAME OF MOTHER unobtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W C Ames
(Address) Sandpoint Idaho

15. Filed Nov 10, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10th, 1930, to Nov. 7th, 1930
that I last saw him alive on November 6th, 1930
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:

Chronic Dysentery
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Sarcoma Sigmoid
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? By Clinical

(Signed) W. B. Graves M. D.
11-8th, 1930 (Address) Sandpoint, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	Nov 10 1930

20. Undertaker Funeral Co Address Sandpoint

RECEIVED DEC 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72670

PLACE OF DEATH
County of Bonner.
City of Coeur d'Alene.

Registration District No. 78
Primary Registration District No. 2155.

Local Registrar's No. 61

(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leo Mayer

(a) Residence. No. I209 5th St. Coeur D' Alene, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 32 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May I5, I898

7. AGE	Years	Months	Days	If LESS than 1 day,
	32	5	I6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Coeur D' Alene
(State or country) Idaho

PARENTS

10. NAME OF FATHER John Mayer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Clara Lauriauld
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada.

14. Informant Mrs. Clara Mayer,
(Address) Coeur DB Alene, Idaho.

15. Filed Nov. 3, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 1, (Day) 1930, (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows: Probable Chronic Valvular Heart Disease.
History Frequent attacks.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? No.
What test confirmed diagnosis? ...
(Signed) L. A. Moon now Coroner.
Nov. 1, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Coeur d'Alene, Ida.	Nov. 4, 1930

20. Undertaker	Address
R. B. Mooney	Coeur d'Alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72671

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. **FULL NAME** Erastus John Yonk

(a) Residence. No. 175 No. 1 West St. Logan, Utah
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	wh	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Pearl Andrews

6. DATE OF BIRTH (month, day and year) Nov. 24 1892

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Automobile dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Logan
(State or country) Utah

PARENTS

10. NAME OF FATHER Wm. F. Yonk
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Denmark
12. MAIDEN NAME OF MOTHER Rebecca Johnson
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant Mrs. J. Yonk
(Address) Logan, Utah

15. Filed Dec. 2, 1930 Jessie N. Lepper State Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930, to Nov. 21, 1930
that I last saw him alive on Nov. 21, 1930
and that death occurred, on the date stated above, at 9:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gun shot wound of epigastrium
Macerating liver - Shot gun
accidental
5½ hours (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date Nov. 21-30
Was there an autopsy? no
What test confirmed diagnosis? Exploratory operation
(Signed) O. P. Egbert M. D.
Nov 25, 1930 (Address) Arco Idaho

19. Place of Burial, Cremation, or Removal: Logan, Utah — Date of Burial: Nov. 26/30 19
20. Undertaker: [illegible] — Address: Logan, Utah

OFFICE PHONE 19

RESIDENCE PHONE 18

G. W. LINDQUIST

MORTICIAN

FLORAL DEPARTMENT

FRESH CUT FLOWERS AND FLORAL DESIGNS

LOGAN, UTAH

November 28,1930

Bureau of Vital Statistics
Boise, Idaho.

Gentlemen;

Enclosed you will find a death certificate for Erastus John Yonk, who was accidentaly shot,by himself,on November 21st in Arco. We mailed certificates to Arco to be signed by the attending physician, as the body was brought here for preparation and burial, and both certificates were returned to us. Apparently they did not know that one should be filed there in Arco. We would appreciate it very much if you would forward the enclosed copy to the registrar in that city, as we are uninformed as to whom this may be.

Thanking you for your kindness, we remain

Respectfully,

G W Lindquist & Son

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72672

PLACE OF DEATH
County of Butte
City of Arco
Registration District No. 59
Primary Registration District No. 2129 Local Registrar's No. 231
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank. Budke

(a) Residence. No. Arco, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unk

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 72			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant Fred Stewart
(Address)

15. Filed Oct. 14, 1930. T. B. Ball Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1930, to Oct 9, 1930
that I last saw h[illegible] alive on Oct 9, 1930
and that death occurred, on the date stated above, at 1 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Spleen
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical exam

Oct 14, 1930 (Signed) C. M. Egbert, M. D.
(Address) Arco Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco, Ida	Oct 12, 1930
20. Undertaker V. F. McFarr.	Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72673

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129

Local Registrar's No. 30

184

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Parra

(a) Residence. No. Howe, Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Unknown	About	40 years	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer J. D. Little

9. BIRTHPLACE (city or town) (State or country) Unknown, Appeared to be a Mexican

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Coroner's Jury
(Address)

15. Filed Oct. 16, 1930 W. Sallee Justice of the Peace acting Coroner. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Knife wound in the thoracic cavity, inflicted, according to Coroner's Jury by Samuel Burton
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) W. Sallee Justice of the Peace acting Coroner, M. D.
, 19 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco, Idaho	Sept. 16, 1930
20. Undertaker	**Address**
Gladys Garnier	Arco, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC [illegible] 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72674

PLACE OF DEATH
County of Canyon
City of Parma
Registration District No. 3
Primary Registration District No. 8007
Local Registrar's No. 18
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Walter Scott Thompson
(a) Residence. No. Parma Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25 - 1863

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	27	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant W Lewis Thompson
(Address) Parma Idaho

15. Filed Dec 1, 1930 Julia Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1930 to Oct. 22 1930
that I last saw h[illegible] alive on Oct 22 1930
and that death occurred, on the date stated above, at 20 m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D M Mitchell, M. D.
10/23, 1930 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Cem.	10/25 1930

20. Undertaker	Address
E. V. Peckham	Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 10 '30

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12675

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 140
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Myrtle May Haskins

(a) Residence. No. 200 Blk on Elgin St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced. (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm S Haskins

6. DATE OF BIRTH (month, day and year) Nov 10 1902

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	--	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ky
(State or country)

PARENTS

10. NAME OF FATHER Vester Hall

11. BIRTHPLACE OF FATHER (city or town) Ky
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Sylvester

13. BIRTHPLACE OF MOTHER (city or town) Ky
(State or County)

14. Informant Wm S Haskins
(Address) % State Pen. Boise Ida

15. Filed 11-12- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 10 1930 to Nov 12 1930
that I last saw h[illegible] alive on Nov 12 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis - Ruptured
from Miscarriage

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible], M. D.
11/12, 1930 (Address) Caldwell Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	11-14-1930

20. Undertaker	Address
Paul L. Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72676

REC'D DEC 10 1930

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 141
(No. Odd Fellows Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

135

2. FULL NAME Herman Bahem
(a) Residence. No. at O.F. Home St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 17 1854

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	- -	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Coal Miner & Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER H.Bahem
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant Mrs Viola Price
(Address) Caldwell Idaho

15. Filed 11-19-, 1930. John L. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 15, 1930
that I last saw h— alive on Nov 13, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Prostate Carcinoma
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Uremia, from retention
Chronic Endocarditis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 11/13/30
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. W. Case M. D.
11/18, 1930 (Address) Caldwell, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	11-17-1930
20. Undertaker	Address
Paul L. Case Caldwell	Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Pitt

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72677

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 142
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Ruth Milisant Isborn
(a) Residence. No. 1715 - N - 15" Boise St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: David Adelbert Isborn

6. DATE OF BIRTH (month, day and year): Aug 25 - 1858

7. AGE: Years 72 | Months 2 | Days 22 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): [illegible] Ohio

PARENTS

10. NAME OF FATHER: Theo. Bennidict
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address): [illegible] Isborn Boise, Ida 1715 - N - 15"

15. Filed 11-20-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1930, to Nov 17, 1930
that I last saw her alive on Nov 17, 1930
and that death occurred, on the date stated above, at 10:20 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Toxemia Myocardial degeneration
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxic Thyroid
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Finding
(Signed) Fred A Pettingill, M. D.
11/18, 1930 (Address) Boise Id.

19. Place of Burial, Cremation, or Removal: Greenleaf | Date of Burial: 11-19 1930

20. Undertaker: C. V. Peckham | Address: Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 0 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72678

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 143
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

20 4

2. **FULL NAME** Enoch Watson

(a) Residence. No. Homedale Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1845

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10. NAME OF FATHER John Watson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Challen Watson
(Address) Homedale Idaho

15. Filed 11-20-, 1930. John S. Meyer, Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 18- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Sudden death from natural causes.
(Advice of County Physician)

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....

(Signed) Paul L. Case, M. D.
Nov. 20-30, 19..... (Address) Coroner Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	11-22-30 19
20. Undertaker	**Address**
Paul L. Case	Caldwell Ida

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72679

PLACE OF DEATH

County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 144
(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George a Nickerson

(a) Residence. No. 919 Chicago St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 15 1857

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	10	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sexton
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Buckstain
(State or country) Missouri

PARENTS

10. NAME OF FATHER Allen Nickerson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Tressie Nickerson
(Address) middleton Ida

15. Filed 11-29-, 1930 John L. Meyer Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1930, to Nov. 23 1930,
that I last saw him alive on Nov 23 1930
and that death occurred, on the date stated above, at 9:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Symptomatic

(Signed) W. W. Staley, M. D.
11-24-, 1930 (Address) 11-24-30

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	11-26 1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.* PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 1 0 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72689

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 145
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101 B

2. FULL NAME Mrs Laura Elizabeth Sherry

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 23 1869

7. AGE Years 61 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morning Sun Iowa

PARENTS
10. NAME OF FATHER John A Owings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Cynthia A.Herrold
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Harrisburg Pa

14. Informant (Address) Norman Owings Nampa Idaho

15. Filed 12-6- 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26-30 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-25- 1930 to 11-26 1930
that I last saw her alive on 11-25 1930
and that death occurred, on the date stated above, at 12.20 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gall Bladder disease
& Old Hernia (duration) 29 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) J. C. Horton, M. D.
12-3, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal Caldwell Ida Canyon Hill Cemetery
Date of Burial 11-28-30 19

20. Undertaker Paul L.Case
Address Caldwell Idaho

J. C. Horton M.D.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

REC'D DEC 1 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72683

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 1005
Local Registrar's No. 146
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Chas E. McClay

(a) Residence. No. 100 Chicago St St.
(Usual place of abode.)
Length of residence in city or town where death occured ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Fannie Miller

6. DATE OF BIRTH (month, day and year) Jan 28-1867

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clay Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meigs Co. Ohio

PARENTS

10. NAME OF FATHER Alvy Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Old Virginia
12. MAIDEN NAME OF MOTHER Jessey Rhoades
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Fannie Miller, Caldwell, Ida

15. Filed 11-29-, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26., 1930, to Nov. 27., 1930
that I last saw him alive on Nov. 26 th, 1930
and that death occurred, on the date stated above, at 3 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Miners Consumption.

(duration) 20 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fragmentary Myocarditis

(duration) 1 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Colorado -
Did an operation precede death? no - Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical.
(Signed) David E Baird, M. D.
Nov. 27, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	11/30 1930
20. Undertaker E V Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72082

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Caldwell, Idaho
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 147
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49C

2. FULL NAME Floyd Clinton Hale

(a) Residence. No. Caldwell, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 7, 1915

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	6	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jackson Hole, Wyo.

PARENTS

10. NAME OF FATHER Charles E. Hale

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary L. Moore

13. BIRTHPLACE OF MOTHER (city or town) (State or County) North Carolina

14. Informant Carlos L. Hale
(Address) Caldwell Ida. R2.

15. Filed 12-1-, 1930 John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Head crushed. Auto Accident.
Accidental.
No inquest.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Paul L. Case, M. Dr.
Nov. 29-30, 19..... (Address) Coroner Caldwell Idaho

19. Place of Burial, Cremation, or Removal: Canyon Hill — Date of Burial: Dec. 1-30 19

20. Undertaker: Paul L. Case — Address: Caldwell, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72683

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 148
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Jordan D. Russell
(a) Residence. No. Caldwell Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 8 1875

7. AGE Years 55 Months 3 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Broken County
(State or country) North Carolina

PARENTS
10. NAME OF FATHER Joe S. Russell
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)
12. MAIDEN NAME OF MOTHER Katherine Ann
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County)

14. Informant (Address) Dennis H. Russell
Middleton Ida

15. Filed 12-2-, 1930. John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 29 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Nov 29, 1930
that I last saw him alive on Nov 15, 1930
and that death occurred, on the date stated above, at 1:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
Several
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
12/1, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Kohlerlawn Cemetery Nampa Idaho
Date of Burial Dec. 2-30

20. Undertaker Paul L. Case
Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72684

PLACE OF DEATH
County of Canyon
City of Middleton

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 148
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Baby Cray
(a) Residence. No. Middleton Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant -

6. DATE OF BIRTH (month, day and year) Nov. 30-30

7. AGE Years Months Days If LESS than 1 day, 2 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Middleton Ida.

PARENTS
10. NAME OF FATHER John. W Cray.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill
12. MAIDEN NAME OF MOTHER Gertrude D (Billings)
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Neb.

14. Informant (Address) John W. Cray.

15. Filed 12-1-, 1930 - John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 30-30, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30., 1930, to Nov. 30., 1930.
that I last saw her alive on Nov. 30., 1930
and that death occurred, on the date stated above, at 4 30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature birth
6 to 7. mo.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Freightened Mother by large dog.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) David E Baird, M. D.
Nov. 30., 1930 (Address) Caldwell. Ida

19. Place of Burial, Cremation, or Removal: Middleton Ida
Date of Burial: Dec1-30

20. Undertaker: Paul L. Case
Address: Caldwell Ida

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72685

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 9
Primary Registration District No. 9005 Local Registrar's No. 150
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. **FULL NAME** Matty Howard.

(a) Residence. No. Wilder St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	

5a. If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND of~~ (or) WIFE of Frank Howard.

6. DATE OF BIRTH (month, day and year) Sept 11 - 1849

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
81	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hall Co
(State or country) Georgia

PARENTS

10. NAME OF FATHER Calvin R. Bales

11. BIRTHPLACE OF FATHER (city or town) Georgia
(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Hale

13. BIRTHPLACE OF MOTHER (city or town) Not Known
(State or County)

14. Informant Mrs. P. W. Kenny
(Address) Caldwell 1502 Belmont

15. Filed 12-5-, 1930 John S. Meyer
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1930, to Dec 1, 1930
that I last saw her alive on Dec 1, 1930
and that death occurred, on the date stated above, at 9:50 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Dilated Heart -
Chronic Nut Nephritis

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab.
(Signed) Robert E Talbot M. D.
Dec 3, 1930 (Address) Wilder Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	Dec 3 1930
20. Undertaker	Address
C. V. Peckham	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 1 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72686

PLACE OF DEATH
County of Canyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 151
(No. Caldwell Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mr. W.D.Culbertson

(a) Residence. No. Marsing Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1864

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER Joseph Culbertson

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Mary Mahaffey

13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant L.M.Culbertson
(Address) Kewanee Ills

15. Filed 12-7- 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 5th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
December 1 1930 to Dec 5 1930
that I last saw him alive on Dec 5 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Art. Sclerosis
(duration) 5 yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Dr Dudley, M. D.
Dec 6, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Cambridge Ohio	
20. Undertaker	Address
Paul L.Case	Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 10 1930

PLACE OF DEATH

County of Canyon

City of Nampa.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1006

(No. Mercy Hosp't.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72687

Local Registrar's No. 126

124

2. FULL NAME Mary A. Goodale.

(a) Residence. No. Rural. St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 5, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	1	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston, Canada.

PARENTS

10. NAME OF FATHER George Cliff.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Edward Goo dale.

(Address) Nampa Idaho

15. Filed 12-5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 1, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Dec 1, 19

that I last saw h er alive on Dec 1, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis,

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel A Swanson M.D.

Dec 6, 1930 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlown Cem.	12-4-30. 19

20. Undertaker	Address
F.K. Robinson.	Ida. Nampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72683

RECEIVED DEC 10 1930

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No.
Primary Registration District No.
Local Registrar's No. 5

(No. Mercy Hospital, Nampa, Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

73

2. FULL NAME John P. Mulholland.

(a) Residence. No. Mountain Home, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Harriett Mulholland

6. DATE OF BIRTH (month, day and year) September 16th 1866

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
64	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Henry Mulholland.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Becky----------
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant (Address) Mrs. Harriett Mulholland. Mountain Home, Idaho.

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 6th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Nov 6, 1930
that I last saw him alive on Nov 5, 1930
and that death occurred, on the date stated above, at 1:15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
General Spinal Sclerosis

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) V. C. Mulholland M. D.
Nov 7, 1930 (Address) Nampa, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	11/8/30 19
20. Undertaker Wm. McBratney.	Address Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72689

PLACE OF DEATH

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2006

Local Registrar's No. 34

(No. Mercy Hosp't)

(If death occurred in a hospital or institution, give its name instead of street and number.)

184 a

2. FULL NAME Eva L. Browning.

(a) Residence. No. Nampa # St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Browning

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Charles Lail

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Anna Clifford

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Frank Browning

(Address)

15. Filed 12-3, 1930 Stella Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Head crushed
Auto accident
Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no Inquest

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Paul L. Case M. D.
Coroner

12-2-30 19 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem.	19

20. Undertaker	Address
F.K.Robinson	Nampa Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 17 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7269

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 133
(No. Mercy Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101B

2. FULL NAME Arthur E. Morey
(a) Residence. No. 514 - 3rd St. So. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie Morey

6. DATE OF BIRTH (month, day and year): Dec. 28th 1884

7. AGE: Years 45 | Months 11 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Morris-Knudsen Construction Co.

9. BIRTHPLACE (city or town) (State or country): Wisconsin

PARENTS

10. NAME OF FATHER: Ed Morey
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: Etta Bice
13. BIRTHPLACE OF MOTHER (city or town) (State or County): unknown

14. Informant (Address): Mrs A. E. Morey, Nampa, Idaho

15. Filed 12-3, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 28th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to Nov 28, 1930
that I last saw him alive on Nov 28, 1930
and that death occurred, on the date stated above, at 3 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Double Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary): None
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) V C Bellwalk, M. D.
Dec 1, 1930 (Address) Nampa Ida

19. Place of Burial, Cremation, or Removal: Rock Erlauer | Date of Burial: 12-2 1930

20. Undertaker: Wm D. Lolley | Address: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72691

PLACE OF DEATH

County of Canyon

City of Nampa.

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 132

(No. Samarition Hosp't.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Charles P. Smith.

(a) Residence. No. 319-15Ave So. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 54. Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) NewYork.

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant H. L. Robins
(Address) Nampa Idaho

15. Filed 12-1, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1929, to Nov. 20, 1930 that I last saw him alive on Nov. 21, 1930 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of pylorus and of liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo. R. Proctor M. D.

Dec 1, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kolerlown Cem.

Date of Burial 11-23-30 19

20. Undertaker F.K.Robinson

Address Nampa Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

RECEIVED DEC 10 1930

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

File No. 72692

Registered No. 131

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace Dixon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 30 (Day) 1914 (Year)

7. AGE: 16 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Barly Dixon

11. BIRTHPLACE OF FATHER (State or Country): Wyo

12. MAIDEN NAME OF MOTHER: Eva Butler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr D Orr Poynter

(Address) Nampa Ida

15. Filed 11-20 1930 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1930, to 11-20-1930 that I last saw him alive on 11-19-1930, and that death occurred on the date stated above, at 7 40 AM.

The CAUSE OF DEATH* was as follows:—

Status Epilepticus

(Duration) Since Yrs. Birth mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D Orr Poynter M. D.

19 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 5 mos. ..... days. In the State 16 yrs. 5 mos. 20 days

Where was disease contracted if not at place of death? Rupert Idaho

Former or usual residence Rupert Idaho

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho

DATE OF BURIAL: 11-20 1930

20. UNDERTAKER: F K Robinson

ADDRESS: Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 10 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72693

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1086
Local Registrar's No. 130
(No. 916 - 1st St. No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. **FULL NAME** Sarah Benner

(a) Residence. No. 916 - 1st St. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 10th 1844

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10. NAME OF FATHER John Benner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penna.
12. MAIDEN NAME OF MOTHER Sarah Hartsell Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penna.

14. Informant (Address) Mrs. Alice Robinson Nampa, Idaho

15. Filed 11-18, 1930 Martha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day) 19?? (Year)

17. I HEREBY CERTIFY, That I attended deceased from
2 years 19.., to Nov. 17, 1930
that I last saw her alive on Nov 16, 1930
and that death occurred, on the date stated above, at 4:10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
(duration) ..yrs 12 mos. ..ds

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) G. R. Proctor, M. D.
11-17-, 1930 (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal Galatia, Illinois — Date of Burial 11-18 1930

20. Undertaker Mrs. Nina M. Talley — Address Nampa, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

REGISTRATION DISTRICT

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72691

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 139
(No. Samaritan Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME August A. Anderson
(a) Residence. No. St. Ureana
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Gertrude B. Anderson

6. DATE OF BIRTH (month, day and year) March 4th 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	8	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Andrew Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden.
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweden

14. Informant Mrs. Gertrude Anderson
(Address) Ureana, Idaho

15. Filed 11-7-30, 19.. Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 — 7 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-26, 1930, to 11-7, 1930, that I last saw h.. alive on 11-7, 1930, and that death occurred, on the date stated above, at 6:50 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of the stomach with metastases to the Cecum & pelvic Colon,
(duration) 3 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Oregon,
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.
(Signed) J. C. Horton, M. D.
11-10, 1930 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa — Date of Burial 11-10 1930
20. Undertaker Wm. D. Talley — Address Nampa, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72695

PLACE OF DEATH

County of Canyon

City of Nampa.

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 128

(No. Lenox Hotel)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dr. Zachery Taylor Holtsclaw.

(a) Residence. No. ~~Lenox Hotel.~~ Larchwood Ida St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

49

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 16, 1847.

7. AGE Years 83 Months 5 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10. NAME OF FATHER B. Holtsclaw.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Anna Holtsclaw,

(Address) Larchwood Iowa.

15. Filed 11-12, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 6, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 6, 1930 that I last saw him alive on Nov 6, 1930 and that death occurred, on the date stated above, at 12:48 P m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. R. Proctor M. D.

Nov 7, 1930 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Larchwood Iowa

Date of Burial 19

20. Undertaker F.K. Robinson

Address Nampa Ida

Proctor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 10 1930

PLACE OF DEATH

County of Canyon

City of Nampa

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72696

Registration District No. 7

Primary Registration District No. 1006

Local Registrar's No. 157

(No. Mercy Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

201

2. FULL NAME Imeritta Marian Dory

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Dory

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 76, Months 2, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Brooklin Wisconsin

PARENTS

10. NAME OF FATHER: Harding A. Colwell

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: Matilda Hollis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennsylvania

14. Informant: Mrs Geo. Hubbert

(Address): Boise Idaho

15. Filed 11-12, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1930, to Oct 31, 1930

that I last saw her alive on Oct 31, 1930

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Coma following fracture of Hip Oct 16 30

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): Fracture of Hip & Nephritis

..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V C Billings D.

Nov 6, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kohlerlawn Cem. Date of Burial: 11-1 1930

20. Undertaker: F. K. Robinson Address: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72698

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 125
(No. 2 miles so. 12th ave. Rd.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME William Franklin Arnold
(a) Residence. No. 2 mi. so. 12th Ave. Rd. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Arnold
6. DATE OF BIRTH (month, day and year) Jan. 12th 1870
7. AGE Years 60 Months 9 Days 14 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer self
9. BIRTHPLACE (city or town) (State or country) Muncie, Indiana

PARENTS
10. NAME OF FATHER John W. Arnold
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Nancy Jane Wooton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Mrs. Estella Arnold Nampa, Idaho
15. Filed 10-27, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 26 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 192.., to Oct 26, 1930
that I last saw him alive on Oct 26, 1930
and that death occurred, on the date stated above, at 7:30 A.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Uremic Coma
(duration) ..... yrs. ..... mos. ..... ds
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) 10 yrs. ..... mos. ..... ds
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) [signature] M. D.
Oct 27, 1930 (Address) [illegible] Nampa Ida

19. Place of Burial, Cremation, or Removal Kohlerlawn-Nampa
Date of Burial 19
20. Undertaker Wm D. Talley
Address Nampa, Ida

VED NOV 28 1930 RECEIVED NOV 19 1930 RECEIVED NOV 22 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72699

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 28

60 B

2. FULL NAME Mary Maccaui
(a) Residence. No. Rupert Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE 54 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address) Rupert Idaho

15. Filed 10-12, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 4, 1930, to Oct 11, 1930
that I last saw her alive on Oct 11, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Hyperthyoidism
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) 0
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? V
Did an operation precede death? yes Date of 10/11/30
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination
(Signed) Celia Kaukly, M. D.
11/12/, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Idaho | Date of Burial 19

20. Undertaker E. D. Whiteman | Address Soda Springs Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72700

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 29

49

2. FULL NAME James W. Young
(a) Residence. No. Challis Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male ~~White~~
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Young 1871

6. DATE OF BIRTH (month, day and year) Dec 25 1[illegible]

7. AGE Years 58 Months 10 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hotel Business
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas

PARENTS
10. NAME OF FATHER Lee Young
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. J. W. Young
(Address) Challis Idaho

15. Filed 10-16, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 16, 1930
that I last saw him alive on Oct. 16, 1930
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:
Cancer of Prostrate Gland
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) ✓
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of 10/16/30
Was there an autopsy? 0
What test confirmed diagnosis? Cystoscopic
(Signed) Ellis Nagel Fry, M. D.
10/16/30, 19 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Challis Idaho
Date of Burial 10-20 1930

20. Undertaker E. L. Whitman F. M. Williams
Address Montpelier ~~Soda Springs~~ Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72701

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Olivar Taber Baker

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah Derinda Baker

6. DATE OF BIRTH (month, day and year) Feb. 12 1859

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	7	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) J.O.Baker Burley Ida

15. Filed 11-15, 1930 F H Cutter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 8 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Oct 8, 1930
that I last saw him alive on Oct 8, 1930
and that death occurred, on the date stated above, at 6:50 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetis Mellitus

about (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis
about (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Forgin, M. D.
....., 19..... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal: Burley Ida
Date of Burial: Oct. 10 1930

20. Undertaker: D. E. Johnson
Address: Burley

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72702

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Hedving Danielson

44

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie Peterson Danielson

6. DATE OF BIRTH (month, day and year) May 9 1859

7. AGE Years 71 Months 5 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Andover
(State or country) Ill

PARENTS
10. NAME OF FATHER Jonas Danielson
11. BIRTHPLACE OF FATHER (city or town) Sweden
(State or Country)
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) Sweden
(State or County)

14. Informant (Address) Fred Danielson Meridian Ida

15. Filed 10-29, 1930 F H Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 11 1930 (Month) (Day) (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 11, 1930
that I last saw him alive on Oct 9, 1930
and that death occurred, on the date stated above, at 7:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach (Pylorus

about (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19.... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Oct 14 1930

20. Undertaker D. E. Johnson
Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 25 1930

PLACE OF DEATH

County of Cassia

City of Burley

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72703

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Eliza Mary Gee

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A.T.Gee

6. DATE OF BIRTH (month, day and year) April 29 1882

7. AGE Years 48 Months 5 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Provo City Utah.

PARENTS

10. NAME OF FATHER William T Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Maria Love less

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Provo Utah

14. Informant (Address) A.T.Gee Burley Ida R.F.D. 4

15. Filed Oct 17, 1930 F. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 16 (Month) (Day) 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Oct 16, 1930 that I last saw her alive on Oct 16, 1930 and that death occurred, on the date stated above, at 1:15 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Joseph Hemstad M. D.

Oct 17, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal Provo Utah. Date of Burial 19

20. Undertaker D.E.Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72704

PLACE OF DEATH
County of Cassia
City of Declo

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Iola Bell Hull

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (Write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of K.C.Hull

6. DATE OF BIRTH (month, day and year) April 6 1872

7. AGE Years 58 Months 6 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER William Clinkinbeard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Eliza Allen

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mis souri

14. Informant (Address) aRalph Hull Declo Ida

15. Filed 10-15, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 19 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to Oct 19, 1930
that I last saw her alive on Oct 19, 1930
and that death occurred, on the date stated above, at 1:30A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Sarcomatosis

..... (duration) ..... yrs. 8 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
Oct 29, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal Declo Ida
Date of Burial Oct 22 1930

20. Undertaker D.E.Johnson
Address Burley

RE... NOV 25 ...

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72705

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Noma Laura Jones

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 3 1919

7. AGE Years 11 Months 6 Days 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) American Falls
(State or country) Idaho

PARENTS

10. NAME OF FATHER Frank L Jones
11. BIRTHPLACE OF FATHER (city or town) American Falls
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Daisy Hansen
13. BIRTHPLACE OF MOTHER (city or town) Ogden
(State or County) Utah

14. Informant Frank L Jones
(Address) Burley Ida

15. Filed 11-15-, 1930 T H Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 22 (Month) 1930 (Day), 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11, 1930, to Oct 22, 1930
that I last saw her alive on Oct 16, 1930
and that death occurred, on the date stated above, at 1.30A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Valv. Ht Disease, Mitral Insufficiency
Acute

..... (duration) ..... yrs. 4 mos. 11 ds.

CONTRIBUTORY (Secondary) Adhesive Pericarditis Ac.
..... (duration) ..... yrs. 4 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Fragier, M. D.
....., 19.... (Address) Burley, Idaho

19. Place of Burial, Cremation, or Removal Neeley Ida
Date of Burial Oct. 24 19

20. Undertaker D.E.Johnson
Address Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-19. NOV 10 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 13706

Local Registrar's No. 10

1. PLACE OF DEATH NOV 19 1930

Registration District No. 91

Primary Registration District No. 2168

County of Clearwater

City of Elk River, Ida.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (unknown) W. J. Leary

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single.

6. DATE OF BIRTH: April (Month) 18 (Day) 1862 (Year)

7. AGE: 68 Yrs. 6 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer): Railroad Construction

9. BIRTHPLACE (State or Country): Ontario.

10. NAME OF Father: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leary.

(Address) @ Hospital

15. Filed Nov. 1 1930 Mildred Hambly Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1930, to Oct 19 1930, that I last saw him alive on Oct 19 1930, and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) unknown yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O M Husted M. D.

Oct. 19 1930 (Address) Elk River, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? not known

Former or usual residence none.

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E M Lewis Palouse Wash. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1930

PLACE OF DEATH

County of Clearwater

City of Pierce

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 90

Primary Registration District No. 2167

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 12707

Local Registrar's No. 84

9

2. FULL NAME Earl Yeager

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W.	S.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 14 1930

7. AGE Years	Months	Days	If LESS than 1 day,
	2	11	.... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None Baby

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Yeager

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Hazel Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Org

14. Informant Joseph Yeager
(Address) Pierce Ida

15. Filed 11/25, 19.... V. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 25 19....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ...., 19...., to ...., 19....

that I last saw h.... alive on ...., 19....

and that death occurred, on the date stated above, at 5:15 m.

The CAUSE OF DEATH* was as follows:

Had no physician. Had the whooping cough & pneumonia

.... (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) ....

.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) V. A. Shaw Coroner, M. D.

11/25, 19.... (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pierce Ida	11/26 19

20. Undertaker	Address
V. A. Shaw	Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RELEASED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72708

PLACE OF DEATH
County of Clearwater
City of Orofino

CERTIFICATE OF DEATH
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 83
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adamjah Jorden

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Amanda Jorden

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Circleville Va,

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Some
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown

14. Informant (Address) Sam Jorden

15. Filed Nov 25, 19?? W. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1928, to Nov 1st, 1930
that I last saw him alive on 10-21-, 1930
and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dropsy - Cardiac Insufficiency
many years
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Val Cure Heart dis
Valvular disease (duration) years yrs. mos. ds.
18. Where was disease contracted if not at place of death? in Virginia
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) W. P. Robertson, M. D.
11-7, 1930 (Address) Orofino

19. Place of Burial, Cremation, or Removal: Weippe — Date of Burial: Nov 9 1930
20. Undertaker: W. P. Pinson — Address: Orofino

RECEIVED JAN 5 1931
RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72709

PLACE OF DEATH
County of Shoshone
City of Orofino

Registration District No. 90
Primary Registration District No. 2187

Local Registrar's No. 82

(No.) 204
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas Hammons

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unacerland

PARENTS

10. NAME OF FATHER Unacertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Unacerland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Ellis Fallen
(Address) Orofino

15. Filed Nov 20, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Found dead out in yard.
had been dead three or four days
was in poor health. heart dease
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) W. A. Shaw Coroner, M. D.
10/31, 19 (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wesseman Cem	Nov 5 1930
20. Undertaker W. D. Simon	Address Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72710

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 5187
Local Registrar's No. 81
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John N McLean
(a) Residence. No. Main St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 67 yrs. mos 10 ds. 17 How long in U. S. if of foreign birth? yrs. mos. ds.

10/D

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 1 - 1863

7. AGE Years 67 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Kempoville Ont

PARENTS
10. NAME OF FATHER John McLean
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Isibella Clark
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland

14. Informant (Address) Mrs Earl Dewar

15. Filed 11/19, 19.... H A Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar, 1927, to Nov 17th, 1930
that I last saw him alive on Nov 17th, 1930
and that death occurred, on the date stated above, at 2 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bulbar Paralysis - 10 days
Heart disease - alcoholism
Lead poisoning (duration) ..... yrs. ..... mos. yrs. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? signs [illegible]
(Signed) [illegible] Robertson M. D.
..., 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal Orofino Ida
Date of Burial Nov 19 1930

20. Undertaker Orofino Mortuary Co Jas N Pratt
Address Orofino Ida

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72711

PLACE OF DEATH
County of Clearwater
City of Pierce

Registration District No. 90
Primary Registration District No. 2107
Local Registrar's No. 80
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

92

2. FULL NAME Dan Mc. Leod

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 56			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) —

PARENTS

10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant W. A. Shaw Coroner
(Address) Orofino

15. Filed 11/18, 19 W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 17 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1:00 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Embolus

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) W. A. Shaw Coroner M. D.
11/18, 19 (Address) Orofino Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Nov 19 19
20. Undertaker	**Address**
W. A. Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72712

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 79

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

177

2. FULL NAME Edward Homer Atherton

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Atherton

6. DATE OF BIRTH (month, day and year) Feb 4 1866

7. AGE

Years	Months	Days	If LESS than 1 day,
64	8	19	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vermont Ill.

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER Dorris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Mrs E. H. Atherton
(Address) Orofino

15. Filed 11/17, 19.... V. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to 11-15, 1930
that I last saw him alive on 11-15-, 1930
and that death occurred, on the date stated above, at 3450 m.
The CAUSE OF DEATH* was as follows:
Over dose - Nitroglycerin -

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dr Aplam diagnosed angina pectoris 6 yrs ago

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? above
(Signed) W. F. Robertson, M. D.
16, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida
Date of Burial: 11/18 19

20. Undertaker: V. A. Shaw
Address: Orofino

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72713

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 7

(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mabel E. Jordan

(a) Residence. No. ..... St. Kellogg, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. Jordan

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59	?	?	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Galena, Nevada

PARENTS

10. NAME OF FATHER Frank Drake

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained

12. MAIDEN NAME OF MOTHER Mary Todd

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Saniyarium
(Address) Orofino, Idaho

15. Filed 11/14, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to November 12, 1930
that I last saw her alive on November 12, 1930
and that death occurred, on the date stated above, at 8.45 P. m.
The CAUSE OF DEATH* was as follows:
General arteriosclerosis

14 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Psychosis with cerebral arterio-sclerosis (duration) 14 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs

(Signed) John Stowell McKelvey, M. D.
Nov. 12, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida — Date of Burial: 19

20. Undertaker: Brown Hamm Co — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72714

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2157

Local Registrar's No. 77

(No.) 157
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME X Nannie A. Hogue

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: J. H. Hogue

6. DATE OF BIRTH (month, day and year): Jan. 29. 1847

7. AGE: Years 83 | Months 9 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Macon Missouri

PARENTS

10. NAME OF FATHER: S. C. R. Hamilton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wayne County Ky. ~~Virginia~~
12. MAIDEN NAME OF MOTHER: Sarah A. Blackwell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky.

14. Informant: Gilbert H. Hogue
(Address) Burley. Idaho

15. Filed Nov 2, 1930 W. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to 11-1 , 1930
that I last saw h[illegible] alive on 10-27- , 1930
and that death occurred, on the date stated above, at 545 P m.
The CAUSE OF DEATH*, was as follows:
Arthritis Deformans
Many years
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ~
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of ~
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) J. R. R. Stinson, M. D.
11-2, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt Hope Ida — Date of Burial: Nov 4 1930

20. Undertaker: W. A. Shaw — Address: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12715

PLACE OF DEATH
County of Franklin
City of We ston

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 79.

(No. 57)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jno Henry Campbell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Julia A. Campbell

6. DATE OF BIRTH (month, day and year) Jan I3 I852

7. AGE	Years	Months	Days	If LESS than 1 day,
	78	I0	0	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Grant Campbell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Ellen Hawk

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs Julia Campbell
(Address) Weston Idaho

15. Filed 11-19-, 1930. J. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17, 193, to Nov 13, 1930
that I last saw him alive on Nov 12, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Diabetes
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of V
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Thos B Holder, M. D.
11/18, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weston Isaho	Nov 18 1930

20. Undertaker M. W. Hendricks Address Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72716

Local Registrar's No. 80

129

PLACE OF DEATH

County of Franklin
City of Weston
Registration District No. 27
Primary Registration District No. 2119
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Nephi Olsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Olsen

6. DATE OF BIRTH (month, day and year): Sept 20 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	I	I6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Weston Idaho

PARENTS

10. NAME OF FATHER: Christen Olsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway
12. MAIDEN NAME OF MOTHER: Anna Ellingson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Norway

14. Informant: Mary Olsen
(Address): Weston

15. Filed 11-19-, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 15, 1930, that I last saw him alive on Nov 15, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Uremia
..... (duration) ..... yrs. ..... mos 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Eugene Hodley M. D.
Nov. 15, 1930 (Address) Preston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal		Date of Burial
Weston	Nov	19 30

20. Undertaker: M. W. Hendricks
Address: Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72717

PLACE OF DEATH

County of Franklin
City of Clifton

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 78.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. FULL NAME Baby Martin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) Clifton Ida.
(State or country)

PARENTS

10. NAME OF FATHER Walter Martin

11. BIRTHPLACE OF FATHER (city or town) Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Cleo Campbell

13. BIRTHPLACE OF MOTHER (city or town) Idaho.
(State or Country)

14. Informant Walter Martin.
(Address) Clifton, Ida.

15. Filed 11-18, 1930. A. R. Cutler
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 17. 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov. 17, 1930.
that I last saw him alive on Nov. 17, 1930
and that death occurred, on the date stated above, at 12 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? — Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. R. Cutler M. D.
Nov 18, 1930 (Address) Preston.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Ida.	Nov. 18 1930

20. Undertaker	Address
None	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72718

PLACE OF DEATH

County of Franklin

City of Fairview

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 76

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Retta Rawlings

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 29 1930

7. AGE Years | Months | Days II | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairview Idaho

PARENTS

10. NAME OF FATHER Oscar Rawlings

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fairview Idaho

12. MAIDEN NAME OF MOTHER Navella Wiser

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lewiston Utah

14. Informant Oscar Rawlings
(Address) Fairview Idaho

15. Filed Nov. 10, 1930. A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 10, 1930

that I last saw her alive on Nov 10, 1930

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ~~yrs.~~ mos. 11 ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Worley, M. D.

Nov. 10, 1930 (Address) Preston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Fairview Idaho Nov | Date of Burial: II 1930

20. Undertaker: M. W. Hendricks | Address: Preston

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No.....

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 76

PLACE OF DEATH
County of Franklin
City of Fairview
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Retta Rawlings

(a) Residence. No..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 29, 1930

7. AGE — Years | Months | Days: 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fairview

PARENTS

10. NAME OF FATHER: Oscar R. Rawlings
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Fairview
12. MAIDEN NAME OF MOTHER: Novella Wiser
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lewiston

14. Informant: Oscar R. Rawlings
(Address) Preston Idaho

15. Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-9, 1930, to Nov 10, 1930
that I last saw h.. alive on Nov 9, 1930
and that death occurred, on the date stated above, at 2 40 a m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Acute upper respiratory infection (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) C. R. Cutler, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview	Nov. 11 1930
20. Undertaker	Address
M. W. Hendricks	Preston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72719

RECEIVED DEC 6 1930

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 77
(No.) 101 A
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clarence DeLoss Hansen

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Mle	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarabell Hansen

6. DATE OF BIRTH (month, day and year) Mar 13 1885

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	8		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Plain City Utah

PARENTS

10. NAME OF FATHER Traber A. Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Emma Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs Clarence D. Hansen
(Address) Preston Idaho

15. Filed Nov. 15, 1930. A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov 13, 1930
that I last saw him alive on Nov. 13, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Eugene Hodley M. D.
Nov. 13, 1930 (Address) Preston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Nov. 16 1930
20. Undertaker	**Address**
M. W. Hendricks	Preston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72729

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

(No. Preston City Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Blanche McCann Raymond

(a) Residence. No. 715-27th. St. St. Ogden, Utah
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm.G.Raymond Jr.

6. DATE OF BIRTH (month, day and year) April 1,1900

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	7	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Smithfield
(State or country) Utah

PARENTS

10. NAME OF FATHER Joseph S.McCann
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Ada Tidwell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant W.G.Raymond Jr.
(Address) Ogden, Utah

15. Filed ....., 19..... L.R. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-6, 1930 to 11-12, 1930
that I last saw h[illegible] alive on 11-12, 1930
and that death occurred, on the date stated above, at 12 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute myocarditis
(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Abortion with hemorrhage
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical
(Signed) C.F. Cutler, M. D.
19..... (Address)

19. Place of Burial, Cremation, or Removal Smithfield Cemetery
Date of Burial 11/16 1930
20. Undertaker G.W. Lindquist
Logan

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72721

PLACE OF DEATH
County of Franklin
City of Franklin

Registration District No. 27
Primary Registration District No. 2119
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 74

42

2. FULL NAME Carol Woodward

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divored
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 14 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	3	16	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Franklin

PARENTS

10. NAME OF FATHER Milton Woodward
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin
12. MAIDEN NAME OF MOTHE Erma Lowe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Franklin

14. Informant Milton Woodward
(Address) Franklin Idaho

15. Filed 11/2/30, 19 C. A. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 1 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-30, 1930, to Nov 1, 1930
that I last saw her alive on Nov 1, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Septic Meningitis

(duration) — yrs. 2 mos. 4 ds.
CONTRIBUTORY (Secondary)? Septic wound on head 3 weeks previous
(duration) — yrs. — mos. 21 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. States, M. D.
Nov. 2, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal		Date of Burial
Franklin Idaho	Nov	3 19

20. Undertaker	Address
M. W. Hendricks	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12723

PLACE OF DEATH
County of Franklin
City of Whitney

Registration District No. 27
Primary Registration District No. 2119

Local Registrar's No. 75

(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Steele

(a) Residence. No. .... St. ....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Norman Steele

6. DATE OF BIRTH (month, day and year) Jan 1 1900

7. AGE	Years	Months	Days	If LESS than 1 day,
	30	10	9	....hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Whitney

PARENTS

10. NAME OF FATHER Gilbert E. Weaver

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Provo Utah

12. MAIDEN NAME OF MOTHER Mary Ann. Gamble

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ogden Utah

14. Informant Mrs Jeanie W. Holt
(Address) Preston Idaho

15. Filed 11/11/, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930, to Nov 9, 1930
that I last saw her alive on Nov 9, 1930
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:
Cerebral embolus -
Rt sided hemiplegia
(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary) Mitral disease of ten
years (duration) 10 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. Stokes, M. D.
Nov. 11, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitney Idaho	Nov. 12 30
20. Undertaker	Address
M. W. Hendricks	Preston Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72723

PLACE OF DEATH

County of Gem.
City of Emmett.

Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arley Watson.

(a) Residence. No. R.# 3 Emmett Idaho. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan.-21-1929.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	10	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Emmett.
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Edgar Watson.

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) South Carolina.

12. MAIDEN NAME OF MOTHER Olga Moulton.

13. BIRTHPLACE OF MOTHER (city or town) Emmett.
(State or County) Idaho.

14. Informant (Address) Frank Moulton.
Emmett Idaho.

15. Filed 12-6, 1930 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov.-4-1930. (Month) (Day) (Year), 19....

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Nov 1, 1930
that I last saw him alive on Nov 1, 1930
and that death occurred, on the date stated above, at 7a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Entero colitis

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Glandular fever following follicular tonsilitis
..... (duration) ..... yrs. 30 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) A. B. Bosch, M. D.
Nov 6, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmet. Idaho.	Nov.5-1930
20. Undertaker	Address
Summers & Krebs.	Boise Idah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72724

PLACE OF DEATH

County of Gem
City of Letha

Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

45

2. **FULL NAME** Mrs Mary Catherine Keppler

(a) Residence. No. none St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Kappler

6. DATE OF BIRTH (month, day and year) Jan. 16 1845

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	10	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Berene
(State or country) Switzerland

PARENTS

10. NAME OF FATHER Sonias David Jindart
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Katherine Keller
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Switzerland

14. Informant (Address) Mr John Leichty
Letha Idaho

15. Filed 12-6-30 19.... J L Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 2-30, 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1930, to Dec 2, 1930
that I last saw her alive on Nov 30, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestinal tuberculosis ?

Several (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
12/4, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal: Letha Ida Cemetery
Date of Burial: Dec 4-30

20. Undertaker: Paul L. Case Caldwell
Address: Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1936

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72795

PLACE OF DEATH
County of Elmore
City of Emmett
Registration District No. 6
Primary Registration District No. ..... Local Registrar's No. 49
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jennie F. Sacum

(a) Residence No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Fem	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Arthur Sacum

6. DATE OF BIRTH (month, day and year) Jan 12 - 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	10	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Richarden Co. Neb

PARENTS

10. NAME OF FATHER Geo. N. Kingebeary
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pavilion N. Y.
12. MAIDEN NAME OF MOTHER Catherine Bieber
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Arthur Sacum

15. Filed 11/17, 1930 J. A. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
1929, 19..., to Nov, 1930
that I last saw her alive on Nov 14, 1930
and that death occurred, on the date stated above, at 4 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATUPE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma arising from
connective tissue covering
right mandible region
2½ (duration) ... yrs, ... mos, ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs, ... mos, ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) C. M. Cummings M. D.
11/17, 1930 (Address) .....

Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	11/18 1930

20. Undertaker C. D. Buckmaster
Address Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72726

PLACE OF DEATH
County of Gem
City of Emmett Registration District No. 4
Primary Registration District No. Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Henry Ray 169

(a) Residence. No. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of Sarah Olive Ray
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 27-1882

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	1	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Genesee
(State or country) Idaho

PARENTS

10. NAME OF FATHER James A. Ray
11. BIRTHPLACE OF FATHER (city or town) Kentucky
(State or Country)
12. MAIDEN NAME OF MOTHER Almeda Robe
13. BIRTHPLACE OF MOTHER (city or town) Kentucky
(State or County)

14. Informant Mrs Olive Ray
(Address)

15. Filed 11/15, 1930 J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Drowned in Payette river
Suicide
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) O. C. Calkins Coroner
11/15, 1930 (Address)

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: 11/16 1930

20. Undertaker: O. D. Buckmeun — Address: Emmett Idaho

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED DEC 10 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72727

Local Registrar's No. 140

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 24

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Ann Radcliffe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: July (Month) 27th (Day) 1869 (Year)

7. AGE: 61 Yrs. 3 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): Lees near Oldham

9. BIRTHPLACE (State or Country): Lancashire, Eng.

10. NAME OF Father: John Wolfenden

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Harriett Mills

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. R. Radcliffe

(Address) Gooding Ida

15. Filed 11/30 1930 J. H. Cromwell Local Registrar

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH: Nov. (Month) 26th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-16- 1930, to 11-26- 1930, that I last saw her alive on 11-26- 1930, and that death occurred on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Nephritis - Uremia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. H. Cromwell M. D.

11/30 1930 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Gooding, Ida

DATE OF BURIAL: 11-30 1930

20. UNDERTAKER: A. E. Thompson

ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72728

PLACE OF DEATH
County of Gooding
City of "

Registration District No. 24
Primary Registration District No.
Local Registrar's No. 141
(No. Goodrich County Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes Campbell

(a) Residence. No. Richfield Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of I E Campbell

6. DATE OF BIRTH (month, day and year) April 7-1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	7	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) St Paul
(State or country) Minn.

PARENTS

10. NAME OF FATHER Agusta Ronisch
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant I E Campbell
(Address)

15. Filed 11/30, 1930 J H Cromwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 19th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1930, to 11-19-, 1930
that I last saw her alive on 11-19-, 1930
and that death occurred, on the date stated above, at 11-25 P m.
The CAUSE OF DEATH* was as follows:

Lymphoid Leukemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J H Cromwell, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	11-22-1930
20. Undertaker	Address
[illegible]	Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72729

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001

Local Registrar's No. 37

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME (No Name Died 7th day) Campbell

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 23 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
			7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Grangeville Idaho

PARENTS

10. NAME OF FATHER: Wilbur L. Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Binder Nebr.
12. MAIDEN NAME OF MOTHER: Bessie Eaton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Winnemuth S.D.

14. Informant: Wilbur L. Campbell
(Address): Grangeville Ida.

15. Filed 12-2-, 1930. B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1930, to Nov. 30, 1930
that I last saw him alive on Nov. 30 - 1930
and that death occurred, on the date stated above, at 5. P. m.
The CAUSE OF DEATH* was as follows:
Spina Bifida
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Congenital
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Myass on back
(Signed) B. Chipman M. D.
12-1-, 1930 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	12-1- 1930
20. Undertaker: Vassar	Address: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 12739

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Idaho
City of Grangeville

Registration District No. 163
Primary Registration District No. 2181
(No.)
Local Registrar's No. 36

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary E Murdock

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Roland Andrews
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N Y St.
12. MAIDEN NAME OF MOTHER Lost Steel
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) D A Murdock Harrison Idaho

15. Filed 12-2-, 1930 B Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
THE CAUSE OF DEATH* was as follows: Accidental Internal Injuries - Automobile Accident on N 95 Highway near Whitebird Idaho
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) B. Chipman M. D.
11-12-, 1930 (Address) Grangeville Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida.	11-12-1930
20. Undertaker Hancock Mort Co.	Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72731

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 35
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1466

2. FULL NAME Evelin Ruth Wallace

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10. NAME OF FATHER Dennis Wallace

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Louisiana

12. MAIDEN NAME OF MOTHER Maud M. Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant Glenn L. Wallace.
(Address) Grangeville Ida

15. Filed 12-2- 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Accidental
Internal Injuries
Automobile Accident
On N.P.S. Highway near Whitebird
Idaho
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) B Chipman M. D.
11-12- 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal: Grangeville Ida — Date of Burial: 11-12- 1930

20. Undertaker: Hancock Mtd. Co — Address: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72732

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Idaho
City of Grangeville Registration District No. 103
Primary Registration District No. 2181 Local Registrar's No. 34
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maud M Wallace

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dennis R Wallace

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Oklahoma
(State or country)

PARENTS

10. NAME OF FATHER Nathan B Jones

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or County)

14. Informant (Address) Mrs J Wallace Grangeville Ida

15. Filed 12-2-, 1930. B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 9: P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fractured Skull - Automobile Accident on U.S. Highway near Whitebird Idaho

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) B. Chipman M. D.
11-12-, 1930 (Address) Grangeville Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	11-12- 1930
20. Undertaker	Address
Duncan Mtf. Co	Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 12783

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Dixie

Registration District No. 163
Primary Registration District No. 2181
Local Registrar's No. 33
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Howard ~~Powelson~~ Powelson

(a) Residence. No. Dixie Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 93 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, ~~or divorced~~
HUSBAND of ~~(or) WIFE of~~ Emma May Powelson

6. DATE OF BIRTH (month, day and year) Feb 15 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington Co. Iowa

PARENTS

10. NAME OF FATHER John Powelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Fidelia Scott
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa

14. Informant (Address) L. R. Powelson Dixie Idaho.

15. Filed 12-2- 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1930 to Oct 10 1930
that I last saw him alive on Oct 6 1930
and that death occurred, on the date stated above, at 330 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma right breast.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypostatic Pneumonia
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? not
What test confirmed diagnosis? Symptoms

(Signed) A. Weber M. D.
Oct 16 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal: Dixie Idaho — Date of Burial: Oct 11 1930

20. Undertaker: Tomp — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7273

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Whitebird

Registration District No. 103
Primary Registration District No. 2101
Local Registrar's No. 32
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Alonzo F Billings

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Ill
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or County)

14. Informant Edna L Lyons
(Address) White Bird Idaho

15. Filed 12-2-, 1930. B Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3, 1930, to Oct 10-, 1930.
that I last saw him alive on Oct 10, 1930
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Cardiac Symptoms
(Signed) B. Chipman M. D.
10-29, 1930 (Address) Grangeville Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Whitebird Ida	10-28-1930
20. Undertaker Hancock Mtd. Co	Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72785

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 31
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Howard Joseph Moran

(a) Residence. No. St.
(If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Belinda Moran

6. DATE OF BIRTH (month, day and year) 1880

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith & Iron
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cashville Penn. U.S.

PARENTS

10. NAME OF FATHER William Moran

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER Matilda McVey

13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Belinda Moran
(Address)

15. Filed 12-2-, 1930. B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 12- 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Alcoholism

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Alcoholism
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Henry Drinker
(Signed) B. Chipman, M. D.
11-14-, 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal: Cottonwood Ida. — Date of Burial: 11-14- 1930
20. Undertaker: Hancock Mtd. Co. — Address: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72736

PLACE OF DEATH

County of Idaho
City of Grangeville

CERTIFICATE OF DEATH

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 30
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

15-9e

2. FULL NAME Genevieve Marrie Hutchen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write ~~the~~ word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 29. 1930

7. AGE Years | Months | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Grangeville
(State or country)

PARENTS

10. NAME OF FATHER Bryon Hutchen
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Bessie Brand
13. BIRTHPLACE OF MOTHER (city or town) Wisconsin
(State or County)

14. Informant (Address) [illegible]

15. Filed 12-2-, 1930. B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1930, to Nov. 15, 1930
that I last saw her alive on Nov. 14, 1930
and that death occurred, on the date stated above, at 2 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pyloric Stenosis of Stomach

..... (duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) Congenital
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Vomiting
(Signed) B. Chipman, M. D.
Nov. 16, 1930 (Address) Grangeville Ida.

19. Place of Burial, Cremation, or Removal: Grangeville Ida | Date of Burial: 11-16- 1930

20. Undertaker: Hancock Mnd. Co. | Address: Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72787

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Lewis County
City of Winchester

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 29
(No.) 240
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Peter Jack Book

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured 1 yrs. 11 mos. 2 ds. How long in U. S. if of foreign birth? 61 yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Jack Book

6. DATE OF BIRTH (month, day and year) Dec 25, 1845

7. AGE: Years 82 | Months 10 | Days 82 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany, Colon

PARENTS
10. NAME OF FATHER Jacob Book
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Mrs Minnie Jack Book Winchester Idaho

15. Filed 12-2-, 1930. B Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 2, 1930, that I last saw him alive on Nov. 1, 1930, and that death occurred, on the date stated above, at 2:15 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) old age

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) A B Halliday M. D.
Nov 2, 1930 (Address) Winchester, Ida.

19. Place of Burial, Cremation, or Removal: Grangeville Ida. — Date of Burial: 11-4-1930

20. Undertaker: Hancock Mtd. Co. — Address: Grangeville Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72739

PLACE OF DEATH
County of Gooding
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Reverdy Warren Crafton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ida E.

6. DATE OF BIRTH (month, day and year) Dec 14, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	10	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Andrew Nelson Crafton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Elvira Richerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Ida E. Crafton
(Address) Jerome Idaho

15. Filed 11/10, 1930 Chas F. Zeller, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930 to Aug 10, 1930
that I last saw him alive on about Aug 10, 1930
and that death occurred, on the date stated above, at 6:30 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Dean F. Price M. D.
, 19 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer, Idaho.	11/10 1930

20. Undertaker	Address
D. A. Henrason	Jerome

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72740

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

58a

2. FULL NAME John De May

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1858 - 6 - 24

7. AGE Years 72 Months 5 Days 0 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Ornsklud Vik

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER ~~Dont~~ Dont-Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Dont-Know.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant John A. Roholt
(Address)

15. Filed Nov. 25, 1930. H. W. Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 23, 1930
that I last saw him alive on Nov 23, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:

Pernicious Anemia - (Dr. Busby)
(duration) + yrs. + mos. + ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no —
What test confirmed diagnosis? —
(Signed) H. W. Shryock, M. D.
Nov. 25, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison. Idaho — Date of Burial 11-26 1930

20. Undertaker Cassedy Funeral Home — Address CDAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12741

Registration District No. 126
Primary Registration District No. 2304
(No.)
Local Registrar's No. 19

748

PLACE OF DEATH
County of Kootenai
City of Harrison
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Sally Jane (Ramey) Roscoe (Rosco)

(a) Residence. No. / St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) March 11 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Boland, Minn.

PARENTS

10. NAME OF FATHER Sylvester Ramey
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Lloyd Roscoe
(Address) Harrison

15. Filed Nov 22, 1930 N W Smyock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov 20, 1930
that I last saw her alive on Nov 20, 1930
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage
5 Hours (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High Blood Pressure
(duration) 2+ yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) N W Smyock, M. D.
Nov 22, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison	Nov. 23 1930
20. Undertaker	**Address**
H. G. Faeger	Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72742

Local Registrar's No. 20

PLACE OF DEATH

County of Kootenai

City of Harrison

Registration District No.

Primary Registration District No.

(No. Connelly Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Samuel M. Logan

(a) Residence. No. 122 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dont-Know day, Dont-Know mother

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Printer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10. NAME OF FATHER David Logan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont-Know

12. MAIDEN NAME OF MOTHER Mary Elizabeth Connelly

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont-Know.

14. Informant Mrs E A Logan
(Address) Spokane Wash.

15. Filed Nov 21, 1930 H W Shymock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 20, 1930
that I last saw him alive on Nov 19, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Chronic cyphosis of liver

(duration) + yrs. + mos. + ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H W Shymock, M. D.
Nov. 21, 1930 (Address) Harrison.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harrison Idaho	11-23 1930
20. Undertaker	Address
Cassedy Funeral Home	Harrison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72743

PLACE OF DEATH
County of Latah
City of Troy

Registration District No. 64
Primary Registration District No. 2144
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Erick Swanberg.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 79 | Months 6 | Days 16 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10. NAME OF FATHER: Erick Swanberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Margrith Danielson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country):

14. Informant: Mrs Axel Benson
(Address): Troy Ida.
15. Filed Nov 30, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF ~~DEATH~~: Nov. 28th 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1930 to Nov. 28, 1930
that I last saw him alive on Nov. 26, 1930
and that death occurred, on the date stated above, at 9. m.
The CAUSE OF DEATH* was as follows:
Senility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Prostatic disease
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Chas. A. Meyer, M. D.
Nov 29, 1930 (Address) Troy, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Dry creek cem — Date of Burial: Nov 30 1930
20. Undertaker: John J. Pickerd — Address: Troy Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72744

PLACE OF DEATH NOV 19 1930

County of Latah

City of Pottatch

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74B

2. FULL NAME Anna Julia Barrager

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr 20 - 1856

7. AGE Years 74 Months 2 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Edward Conner

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Head

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mrs. L. W. Queener.
(Address) Palouse, Wash.

15. Filed July 14, 1930 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11th, 1930, to July 11th, 1930 that I last saw her alive on July 11th 1930 and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Thompson, M. D.

July 14th, 1930 (Address) Pottatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Moscow Ida

Date of Burial July 15 1930

20. Undertaker J. M. Irwin

Address Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72745

Local Registrar's No.

PLACE OF DEATH
County of Latah
City of Princeton
Registration District No. 65
Primary Registration District No. 2145
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Arthur Turner

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minervia Turner

6. DATE OF BIRTH (month, day and year) Feb. 16, 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ## Oregon

PARENTS

10. NAME OF FATHER James Turner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Knot
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant Dale Turner
(Address) Princeton, Ida.

15. Filed Dec 2nd, 1930 J. J. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1 P.M m.
The CAUSE OF DEATH* was as follows:
Inflamatory rheumatism
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) 16 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

9/1 (Signed) H. R. Short Coroner, M. D.
, 19 30 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Juliaetta, Ida.	12/2/30 19

20. Undertaker H. R. Short — Address Moscow

RECEIVED NOV 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72746

PLACE OF DEATH
County of Latah
City of Pottatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Maude Brynaldson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H Brynaldson

6. DATE OF BIRTH (month, day and year)

7. AGE Years 48 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Chicago Ill

PARENTS
10. NAME OF FATHER Snyder
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Christina Hoffman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Frank W Brynaldson Pottatch Ida

15. Filed Oct 21st, 1930 J. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17th, 1930, to Oct 19th, 1930
that I last saw her alive on Oct 19th, 1930
and that death occurred, on the date stated above, at 11 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) ~~10~~ yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis c̄ Hypertension
(duration) 10 or more yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Hyden Hancher, M. D.
Oct 21, 1930 (Address) Pottatch

19. Place of Burial, Cremation, or Removal Garfield Wash
Date of Burial Oct 22 1930

20. Undertaker J. M. Irvine Palouse Wash
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72747

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. FULL NAME John Ruefpel

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 5 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Irta Langreds
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant (Address) Mrs John Ruefpel Princeton Ida.

15. Filed Nov 10 1930 J. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 9th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th 1930, to Nov 9th 1930, that I last saw him alive on Nov 9th 1930, and that death occurred, on the date stated above, at 5 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute appendicitis

(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Nov 8th
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) J. W. Thompson, M. D.
Nov 10th 1930 (Address) Potlatch

19. Place of Burial, Cremation, or Removal: Potlatch Ida — Date of Burial: Nov 11 1930
20. Undertaker: Potlatch Trivin Palouse Wash. — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. RECEIVED NOV 19 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Pottatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

File No. 72748

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Himmelman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: June (Month) – (Day) 1859 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known (Germany)

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Glen Himmelman

(Address) Pottatch

15. Filed Oct 8th 1930 D. J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

64B

16. DATE OF DEATH: Oct (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19..., that I last saw h ✓ alive on ✓ 19..., and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.

Oct 8th 1930 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: El Irwin Pottatch

DATE OF BURIAL: Oct 9th 1930

20. UNDERTAKER: E. Irwin

ADDRESS: Palouse Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72749

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mary Jane Craig

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 - 1851

7. AGE: Years 78 | Months 11 | Days 16 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS
10. NAME OF FATHER: J. Berry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: J. A. Craig
(Address) Palouse Wash

15. Filed Sept 28, 1930 Dr J.W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from never saw her or, 19
that I last saw attended her while alive
and that death occurred, on the date stated above, at 10 30 A m.
The CAUSE OF DEATH* was as follows:
Probably due stroke of paralysis that occured Sat. 27 of Sept. and due to her age. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. K. Wolfe M. D.
Sept 29, 1930 (Address) Palouse, Wn

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Truggee Cem | Date of Burial: Sept 30 1930

20. Undertaker: E. M. Brown | Address: Palouse Wash

RECEIVED NOV 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72750

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1D 1 1
Local Registrar's No. 56
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

112

2. FULL NAME Inger P. Jacobsen

(a) Residence. No. Orchard Ave. St.
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peder Jacobsen

6. DATE OF BIRTH (month, day and year) April ~~2~~ 9, 1855

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	6	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10. NAME OF FATHER Lars Velle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Gertie Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant J.J. Wigen
(Address) Moscow, Idaho

15. Filed 11/20/30 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. 28, 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct. 10, 1930, to Oct. 28, 1930
that I last saw her alive on Oct 28 1930 19
and that death occurred, on the date stated above, at 12:25 A m.
The CAUSE OF DEATH* was as follows:

Acidosis

(duration) yrs. mos. ds.
CONTRIBUTORY Diabetes
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
10/29, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lacrosse, Wn.	10-30 1930

20. Undertaker H. R. Short
Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 28 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72751

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1511
(No. Rural)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 55

2. FULL NAME Thomas Nutterville

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 21 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
~~Male~~	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie Nutterville

6. DATE OF BIRTH (month, day and year) Mar. 4, 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	7	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario, Canada

PARENTS

10. NAME OF FATHER John Nutterville
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Bridget Brady
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Canada

14. Informant Mrs. Minnie Nutterville
(Address) Moscow, Ida.

15. Filed 11/20, 1930 Harry Cochrane Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:
Reoccurance of paralytic stroke

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) H. R. Short, Coroner, M. D.
10/28, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	10-29 1930
20. Undertaker H. R. Short	Address Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72752

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 54

49

2. FULL NAME Peter Kennedy

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Abrigail Kennedy

6. DATE OF BIRTH (month, day and year): June 29, 1850

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	3	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): St. John Newbrunswick

PARENTS

10. NAME OF FATHER: Richard Kennedy

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Newbrunswick

12. MAIDEN NAME OF MOTHER: Ann Morrow

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Newbrunswick

14. Informant: Mrs. Harry Driscoll
(Address): Moscow, Idaho

15. Filed 11/20, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 16, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1930, to Oct. 16, 1930 that I last saw him alive on Oct 16, 1930, 19 and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the prostate gland.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas. L. Gritman, M. D.

10/18, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 10/18/30 19

20. Undertaker: H. R. Short

Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72753

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 53

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88 B

2. FULL NAME Herman N. Kalinowski

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie

6. DATE OF BIRTH (month, day and year): April 12, 1874

7. AGE: Years 56 | Months 6 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Dealer in Farm Machinery

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs. Minnie Kalinowski
(Address): Moscow, Ida.

15. Filed 11/20, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Octiber 12, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 9, 1930, to Aug 18, 1930 that I last saw him alive on about Oct 4 1930 and that death occurred, on the date stated above, at 3 30 p m.

not professionally

The CAUSE OF DEATH* was as follows:

Coronary disease
Myocarditis. This was diagnosis in August.

..... (duration) ..... yrs. some mos. ..... ds.

CONTRIBUTORY (Secondary) Was dead when I arrived. Had severe tonsillitis in Aug when I discovered Heart lesion. (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

10/13, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 10/14/30 19

20. Undertaker: H. R. Short

Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72754

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 6e
Primary Registration District No. 2179
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 20

126

2. FULL NAME Mrs. Jessie Moore

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sam N. Moore

6. DATE OF BIRTH (month, day and year): Dec 3rd 1870

7. AGE: 59 Years | Months: 11 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Keytsville Mo

PARENTS

10. NAME OF FATHER: William Pierce
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Flora Mitchell
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: Homer Moore
(Address): Craigmont Ida

15. Filed 11/5, 1930 P. G. Dunlap Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1930, to Nov. 3, 1930
that I last saw her alive on Nov. 2, 1930
and that death occurred, on the date stated above, at 2:50 A. m.
The CAUSE OF DEATH* was as follows: Peritonitis
..... (duration) ..... yrs. ..... mos. 27 ds.
CONTRIBUTORY (Secondary): acute attack of chronic cholecystitis (duration) 20 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? Yes Date of Oct. 13, 1930
Was there an autopsy? No
What test confirmed diagnosis? Symst. + phy. finding
(Signed) A. B. Halliday, M. D.
Nov. 3, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: IOOF Cemetery Craigmont Ida | Date of Burial: 11/4/1930

20. Undertaker: Craigmont Hdwe Co | Address: Craigmont Ida

RECEIVED NOV 18 1930

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72755

1. PLACE OF DEATH

County Lincoln State IDAHO Registered No.

Township or Village or

City Shoshone No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Christian Hansen

(a) Residence: No. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Marie Hansen

6. DATE OF BIRTH (month, day, and year) Feby 19 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	74	8	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Blacksmith

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) Nov 1916

11. Total time (years) spent in this occupation 30

12. BIRTHPLACE (city or town) Cohenhagen (State or country) Denmark

FATHER

13. NAME Unknown (Hansen)

14. BIRTHPLACE (city or town) (State or country) Denmark

MOTHER

15. MAIDEN NAME Bille

16. BIRTHPLACE (city or town) (State or country) Denmark

17. INFORMANT A. H. Hansen
(Address) Shoshone Ida

18. BURIAL, CREMATION, OR REMOVAL
Place Salt Lake City, Utah Date Nov 15 1930

19. UNDERTAKER C. E. Hickok
(Address) Shoshone Ida

20. FILED Nov 17 1930 J. A. Fuller Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Nov 14 1930

22. I HEREBY CERTIFY, That I ~~attended deceased from~~ did not attend deceased from 19 to 19
I last saw h alive on 19 ; death is said to have occurred on the date stated above, at 7.30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Probable cause of Death Chronic Myocarditis	
Senility	

Other contributory causes of importance:

Name of operation none Date of

What test confirmed diagnosis? Phy Exam Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) F. E. Barnett, M. D.
(Address) Shoshone Ida

c11—8184

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—2091
V. S. No. 98

N... ...ry item of information should be ...y supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72756

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 69

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

47

2. FULL NAME Marvin Dale Reyburn

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 13, 1929

7. AGE Years Months II Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise Idaho

PARENTS
10. NAME OF FATHER W.B.Reyburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Birdie Perry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant W.B.Reyburn
(Address) Rexburg

15. Filed Dec 4, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1930, to Dec. 2, 1930
that I last saw him alive on Dec. 2, 1930
and that death occurred, on the date stated above, at 11:20 A.m.
The CAUSE OF DEATH* was as follows:
Acute pericarditis
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) M Sutherland, M. D.
12-2, 1930 (Address) Rexburg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rexburg Cemetery
Date of Burial 12/3 1930

20. Undertaker Russel P. Flamm
Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72757

PLACE OF DEATH

County of Madison
City of Rexburg

CERTIFICATE OF DEATH

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 68
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

205-B

2. FULL NAME Glenda Perrenoud
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 21—1929

7. AGE: Years 1 | Months 1 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Plano Idaho

PARENTS

10. NAME OF FATHER Leo H. Perrenoud
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Plano Ida
12. MAIDEN NAME OF MOTHER De Lila Sourey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Hibbard Ida

14. Informant (Address) Leo H. Perrenoud Plano Ida

15. Filed Dec 4, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Baby was dead when brought to office, 19..., to ..., 19...
that I last saw h..... ~~alive~~ on Nov 27—, 1930
and that death occurred, on the date stated above, at 9 AM m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Undetermined. Spinal fluid (Post mortem specimen) was clear & contained no pus. No meningococcus - no pneumococcus found. L.D.S. Hospital (Ida Falls Ida) laboratory report.
..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Plano - Idaho
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Tom A Rich, M. D.
12/1/1930 (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal: Plano Ida
Date of Burial: Nov. 29 1930

20. Undertaker: Tom J Keller
Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72758

PLACE OF DEATH
County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 67
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Golden J Wasden

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Infant.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 19th 1930.

7. AGE Years | Months 3 | Days 8. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Salem Ida.
(State or country)

PARENTS

10. NAME OF FATHER Fay Wasden
11. BIRTHPLACE OF FATHER (city or town) Gunnison Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Emma James
13. BIRTHPLACE OF MOTHER (city or town) Rosett Utah
(State or County)

14. Informant (Address) Fay Wasden Salem Idaho

15. Filed Dec 4, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27, 1930, to Nov 27, 1930
that I last saw him alive on Nov 27, 1930
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis
..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? place of death
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? symptoms

12/1 (Signed) Lorin H Rich, M. D.
1930 (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal Rexburg Idaho | Date of Burial Nov. 29 1930

20. Undertaker Vern G Keller | Address Rexburg

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72759

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Madison
City of Canyon Creek

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 66
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Baby — Casper — Eva June

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canyon Creek Ida.

PARENTS

10. NAME OF FATHER E. L. Casper.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewisville Ida.
12. MAIDEN NAME OF MOTHER Gomonia Ard.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas.

14. Informant E L Casper
(Address)

15. Filed Dec 4, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
—, 19..., to —, 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ...m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Opened after the baby had died. The probable Cause of death - acute Otitis media. (duration) ... yrs. ... mos. ... ds

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. Ruther Bennett, M D
11-23, 1930 (Address) Kellogg, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewisville Ida.	Nov. 24 1930

20. Undertaker Address
Glenn J Keller. Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72760

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 65
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME Dallas William Byran
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 22. 1928

7. AGE Years 2. Months 1 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Neon Idaho
(State or country)

PARENTS

10. NAME OF FATHER Arley J. Byran
11. BIRTHPLACE OF FATHER (city or town) South Weber Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Perrmend
13. BIRTHPLACE OF MOTHER (city or town) Plano Ida.
(State or County)

14. Informant (Address) Arley J. Byran Plano Ida #3.

15. Filed Dec 4, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 21st (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 21, 1930
that I last saw him alive on Nov 21, 1930
and that death occurred, on the date stated above, at 7 13 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestinal toxemia
type undetermined
Child was dying when I first was called to see him
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Plano Idaho
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? symptoms
(Signed) Korin F Rich, M. D.
11/23, 1930 (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal Neon Idaho
Date of Burial Nov. 24 1930

20. Undertaker Vern J Keller
Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72761

DEC 10 1930

PLACE OF DEATH
County of Madison
City of Thornton Route 1
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 64
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

170

2. FULL NAME Robert G. Hill
(a) Residence. No. ... St. ...
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. ~~If married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Sarah Hill

6. DATE OF BIRTH (month, day and year) March 27-1866

7. AGE Years 64 Months 7 Days 21 If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming.
(b) General nature of industry, business, or establishment in which employed (or employer) ...
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wellsville Utah

PARENTS
10. NAME OF FATHER Robert B. Hill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Marguerite C. Gardner
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Canada

14. Informant (Address) Mrs. Robert G. Hill Thornton Idaho

15. Filed Dec 4, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gun shot wound in chest self inflicted (Suicide)
... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) F. Edmundsman, M. D.
Nov. 18, 1930 (Address) Coroner Rexburg

19. Place of Burial, Cremation, or Removal Burton Cemetery
Date of Burial Nov. 21 1930

20. Undertaker Vern J. Keller
Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72762

Registration District No.
Primary Registration District No.
Local Registrar's No. 63

PLACE OF DEATH

County of Madison
City of Rexburg
(No. Rexburg General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Masao Kikida

(a) Residence. No. Rexburg RFD 7 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	Jap	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 10 1917

7. AGE	Years	Months	Days	If LESS than 1 day,
	13		6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Idaho

PARENTS

10. NAME OF FATHER T. Kikida
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Japan
12. MAIDEN NAME OF MOTHER Make Hayashi
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Japan

14. Informant Fugie Kikikada
(Address) Rexburg Idaho

15. Filed Dec 4, 1930. D. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 16, 1930
that I last saw him alive on Nov. 14, 1930
and that death occurred, on the date stated above, at 9:9 m.
The CAUSE OF DEATH* was as follows:
Endocarditis.
(Anasarca)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D. R. Young, M. D.
Nov. 17, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Cemetery	11/18 1930
20. Undertaker	Address
Russell P. Flamm	Rexburg

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 12764

PLACE OF DEATH

County of Madison

City of Lyman

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 61

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clyde Daniel Weeks

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 4th 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9.	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Lyman Ida.

PARENTS

10. NAME OF FATHER Fredrick Weeks

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lyman Ida.

12. MAIDEN NAME OF MOTHER Veda McIntire

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lyman Ida.

14. Informant Freeman McIntire
(Address) Lyman Idah.

15. Filed Dec 4, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 15th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Nov. 15, 1930.

that I last saw him alive on Nov. 15, 1930.

and that death occurred, on the date stated above, at 4 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

.....

.....

.....(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. Rutherford, M. D.

12-15, 1930 (Address) Lexington Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Sutton Cemetary	Nov 17 1930

20. Undertaker Dean J. Keller Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72765

DEC 10 1930

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 60
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Charlotte Jeannine Williams
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 3th 1930.

7. AGE Years X Months X Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Ida.

PARENTS
10. NAME OF FATHER Howard E. Williams
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota.
12. MAIDEN NAME OF MOTHER Sarah Trost.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Rexburg Ida

14. Informant (Address) Howard E. Williams Rexburg Idaho.

15. Filed Dec 4, 1930 J. R. Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 11th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 11, 1930
that I last saw her alive on Nov 11, 1930
and that death occurred, on the date stated above, at 11.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature birth
not viable.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Date of pregnancy.
(Signed) Louis F. Rich M. D.
12, 1930 (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal Rexburg
Date of Burial Nov. 11th 1930

20. Undertaker Vern J. Keller
Address Rexburg

DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72766

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 59
(No. 177)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Tom Galonet

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Negroan	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
51	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None -
(b) General nature of industry, business, or establishment in which employed (or employer) Worked in Hotel at
(c) Name of employer Rexburg.

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant Rec'd from Fishing Licensed (Address) Council on Signif

15. Filed Dec 4, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1930, to Nov. 8, 1930
that I last saw him alive on Nov. 8, 1930
and that death occurred, on the date stated above, at 9:08 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows

Poison Alcohol
(Alcohol intoxication)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of -
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) H B Rigby, M. D.
Nov. 25, 1930 (Address) Rexburg

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Ida.	Nov. 11th 1930
20. Undertaker Thorn J Keller	Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72767

PLACE OF DEATH

County of Madison

City of Rexburg #1

Registration District No. 100

Primary Registration District No. 2178

Local Registrar's No. 58

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Jacob Christian Peterson.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W.

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Annie Dee Drinkwater Peterson

6. DATE OF BIRTH (month, day and year) Aug. 29. 1868

7. AGE: Years 62 Months 2 Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10. NAME OF FATHER Jessie Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER N. K.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Julie Siepert.
(Address) Rexburg #1

15. Filed Dec 4, 1930 J. R. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1930, to Nov 4, 1930

that I last saw him alive on Nov 4 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Artero-Sclerosis (interstitial nephritis)

..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? place of death

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms &

(Signed) Lottie S. Rich, M. D.

11/6/30, 19.... (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Burton Ida. Date of Burial: Nov. 8 1930

20. Undertaker: Vern J. Keller Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72768

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 196
Primary Registration District No. 1009
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

129

2. FULL NAME Margaret Lewis.
(a) Residence. No. 312 Miller St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. Lewis.
6. DATE OF BIRTH (month, day and year) Oct, 25, 1865
7. AGE Years 65 Months — Days 11 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS
10. NAME OF FATHER Geo Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Elizabeth Wonder's
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant George Lewis
(Address) Lewiston Idaho.
15. Filed 11-7 30, 19 J. M. Lyle Registrar
By N.B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 6 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11-1-30, 19, to 11-7-, 1930
that I last saw her alive on 19
and that death occurred, on the date stated above, at 1 45 p m.
The CAUSE OF DEATH* was as follows:
Chronic myophrits
(duration) 11 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? signs + symptoms
(Signed) , M. D.
11/3, 1930. (Address) C. S. White

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Garfield Wash
Date of Burial 11/9 1930
20. Undertaker Labrar Mortuary Inc.
Address Lewiston Ida

Dr Rouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72769

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 94
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

161a

2. FULL NAME Mary Barbour
(a) Residence. No. 531 Snake River Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 9 - 1930

7. AGE Years — Months — Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS
10. NAME OF FATHER T J Barbour.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana
12. MAIDEN NAME OF MOTHER Mary Owen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant T J Barbour.
(Address)

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-9-1930, 19...., to 11-10-1930, 19....
that I last saw her alive on 11-10-1930, 19....
and that death occurred, on the date stated above, at 10 45 A.m.
The CAUSE OF DEATH* was as follows:
Premature.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Trimitition

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Signs & symptoms
(Signed) H. Rouse, M. D.
11-20-30, 19.... (Address) Lewiston, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho — Date of Burial 11/11 1930

20. Undertaker Vassar Mortuary Inc — Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72770

PLACE OF DEATH

County of Nez Perce.

City of Idaho.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

46

2. FULL NAME Rachel Ann Evans.

(a) Residence. No. St. Nez Perce, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) December 7th, 1872.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57.	11.	3.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois.

PARENTS

10. NAME OF FATHER David H. Davis.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales.

12. MAIDEN NAME OF MOTHER Anna Jones.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales.

14. Informant John Evans
(Address) Nez Perce, Idaho.

15. Filed 11-13, 1930. J. M. Lyle By N.B. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 10, 1930
that I last saw her alive on Nov 10th 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:

Post Operative Shock
(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Adenocarcinoma of Uterus
(duration) yrs. + mos. ds.

18. Where was disease contracted if not at place of death? Craigmont Ida

Did an operation precede death? Yes Date of Nov 10/30

Was there an autopsy? No

What test confirmed diagnosis? Uterine Scrappings

(Signed) O. C. Carrasco, M. D.
11/12/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dedham, Iowa.	19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72771

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

(No. White Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

31

2. FULL NAME Ardra V. Parker.

(a) Residence. No. St. Lewiston Orchards.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Parker.

6. DATE OF BIRTH (month, day and year) April 30th, 1899.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31.	6.	10.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER James A. Parker.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Dora Moore.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant Mrs. A. V. Parker.
(Address) Lewiston, Idaho.

15. Filed 11-13, 1930 J. M. Lyle By NB Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 10, 1930
that I last saw him alive on Nov 10, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows: Pulmonary T. B. (acute)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cardinal Symptom

(Signed) E. L. White, M. D.

11/12/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	11/12/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72772

PLACE OF DEATH
County of Nezperce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009 Local Registrar's No.
(No. St Joseph Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME John Mc Kinney
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Mqle
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1865

7. AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Willamette, Oregon

PARENTS
10. NAME OF FATHER Joseph Mc Kinney
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Nancy Wiseman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) Mrs Tom Florence Clarkston, Wash.

15. Filed, 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 29, 1930
that I last saw him alive on Nov 29 1930
and that death occurred, on the date stated above, at 7 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Brights Dis
Arteriosclerosis, Mitral
Regurg, Cholecystitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Wm Atwood M. D.
Dec 1, 1930 (Address) Clarkston

19. Place of Burial, Cremation, or Removal Clarkston, Wash. Date of Burial 12/1/30 19

20. Undertaker H.R.Merchant Address Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Alley

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12773

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 98

Primary Registration District No. 1009

Local Registrar's No.

(No. 209 11th, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Henry Castle

(a) Residence. No. 209 11th, Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 1st, 1874.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56.	8.	26.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mill worker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Clearwater Timber Company.

9. BIRTHPLACE (city or town) (State or country) Correctionville, Iowa.

PARENTS

10. NAME OF FATHER William Henry Castle.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Melissa Lewist

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Mrs Wm H Castle.
(Address) Lewiston, Idaho.

15. Filed Nov. 30, 1930 Beatrice N Lepper Registrar
State

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1930, to Nov 27, 1930
that I last saw him alive on Nov 27, 1930
and that death occurred, on the date stated above, at 8:130 a.m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Influenza

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam

(Signed) Ruepb M. Alley M. D.
11/30/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	11/30/30. 19
20. Undertaker	**Address**
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12774

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. St Joseph)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rose Jefferson Red Elk 31

(a) Residence. No. / Lapwai Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	Indian	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cyrus Red Elk

6. DATE OF BIRTH (month, day and year) June 16 - 1913

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	4	17	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Daniel Jefferson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oklahoma
12. MAIDEN NAME OF MOTHER Agnes Matthews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Cinda Jefferson
(Address) Oregon

15. Filed 11-7-, 1930 J M Tuttle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1930, to Nov 3, 1930
that I last saw her alive on Nov 3 1930
and that death occurred, on the date stated above, at 8 20 m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W O Clark, M. D.
Nov 7, 1930 (Address) Fenton Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Slickapoo Mission	11/4 1930
20. Undertaker	Address
Vassaus Mortuary	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lyle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72775

PLACE OF DEATH

County of Nez Perce.

City of Near Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Henry Baumgartner.

(a) Residence. No. St. Clarkston, Washington.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Philipine A. Baumgartner.

6. DATE OF BIRTH (month, day and year): Jan. 16th, 1868.

7. AGE: 62. Years; Months: 9.; Days: 15.; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired farmer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Newulm, Minn.

PARENTS

10. NAME OF FATHER: William Baumgartner.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Henryetta Mollman.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany.

14. Informant: Mrs Henry Baumgartner
(Address) Clarkston, Washington.

15. Filed 11-4, 1930 J. M. Lyle M.D. Registrar
By N. B.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 1st, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ruptured Coronary Artery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sudden death

(Signed) E M Brown Coroner, M. D.

11/1, 1930 (Address) Lewiston Idaho,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Genesee, Idaho.

Date of Burial: 11/3/30. 19

20. Undertaker: Henry Merchant.

Address: Clarkston, Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12776

PLACE OF DEATH

County of Nez Perce.

City of Idaho.

Registration District No. 9C

Primary Registration District No. 1009

Local Registrar's No.

(No. 311 9th, Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bradley James Sanders.

(a) Residence. No. 311 9th, Avenue. ~~St.~~
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 14th, 1927.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
2.	11.	20.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER A. O. Sanders.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Norway.

12. MAIDEN NAME OF MOTHER Margaret McCabe.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ohio.

14. Informant
(Address) Lewiston, Idaho.

15. Filed 11-6, 1930 J. M. Lyle Registrar
By ~~M.S.~~

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 4th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from
..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 4:30 P.M. a.m.

The CAUSE OF DEATH* was as follows:
Complications following measles. No doctor in attendance.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Yes.
What test confirmed diagnosis?

(Signed) Brower - Coroner.
11/6/30. 19... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	11/6/30. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72777

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 162)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Robert Wall

(a) Residence. No. 724 13th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER J J Wall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Mary Andrews
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash

14. Informant J J Wall
(Address) 724 13th ave Lewis

15. Filed 11-7-1930 J M. Lytle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
10 AM 11/4, 1930 to 1139 AM 11/4, 1930
that I last saw him alive on 11/4, 1930
and that death occurred, on the date stated above, at 11 30 A m.
The CAUSE OF DEATH* was as follows:
Status lymphaticus
2 hrs.
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? C
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy + microscopic
(Signed) P. G. Hatfield, M. D.
11/7, 1930 (Address) Lewiston, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston	11/6 1930
20. Undertaker	Address
Dacus Mortuary Inc	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72778

Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 911 St. Joseph)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

2. FULL NAME Barbara L. Taylor

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 22 - 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	—	4	—	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston Idaho

PARENTS

10. NAME OF FATHER Eugene Taylor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida ho
12. MAIDEN NAME OF MOTHER Esther Pethichard
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida ho

14. Informant Eugene Taylor
(Address) Lewiston

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16. 1930. to Nov. 23 1930.
that I last saw her alive on Nov. 23 1930.
and that death occurred, on the date stated above, at 6½ 30 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia -

(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Faulty diet

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Clinical - Signs.
(Signed) William Pethichard, M. D.
Nov. 23, 1930. (Address) Lewiston - Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	11/26 1930

20. Undertaker Vassar Mortuary Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

white

DO NOT WRITE IN THIS SPACE
State File No. 72779

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) 184 C
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James N. Eller.

(a) Residence. No. St. Vaha, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 8th, 1872.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58.	0.	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arkansas.

PARENTS

10. NAME OF FATHER Joseph F. Eller.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina.
12. MAIDEN NAME OF MOTHER Susie McFerron.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Mrs J.A. Eller
(Address) Vaha, Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov 27, 1930, to Nov 27, 1930
that I last saw him alive on Nov 27, 1930
and that death occurred, on the date stated above, at 2 20 m.
The CAUSE OF DEATH* was as follows:

Basil Skull fracture 2 hours
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Accident Run down by automobile.
(duration) yrs. mos. ds.

18. Where was disease contracted — if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.
11/28/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	11/29/30. 19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lyle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72780

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1069

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

-48 (B

2. FULL NAME Charles J. Boyd.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: 72. Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Patient County farm.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not known.

PARENTS

10. NAME OF FATHER: Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not known.

14. Informant: Chas. Morlan
(Address) Lewiston, Idaho.

15. Filed 12-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 18th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Nov., 1930
that I last saw him alive on Nov 10, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) J. M. Lyle, M. D.

11/19/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. | Date of Burial: 11/25/30. 19

20. Undertaker: Brower-Wann Company. | Address: Lewiston, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72781

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Alvin J. Hastings
(a) Residence. No. Snake River Ave St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20, 1873

7. AGE Years 57 Months 6 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garfield, Wash.

PARENTS
10. NAME OF FATHER E.G. Hastings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Davis Co. Iowa
12. MAIDEN NAME OF MOTHER Alice S, Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Davis County Iowa

14. Informant (Address) E. J. Hastings Lewiston Idaho

15. Filed 11-24, 1930 J. M. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 21st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th, 1930, to Nov 21st, 1930
that I last saw him alive on Nov 21st, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis
(duration) + yrs. mos. ds.

18. Where was disease contracted if not at place of death? Pomeroy Wash
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory & physical exam
(Signed) O. E. Carsson, M. D.
11/23rd, 1930 (Address) Lewiston Idaho

19. Place of Burial, Cremation, or Removal Pomeroy Wash
Date of Burial 11/23 1930

20. Undertaker H. R. Merchant
Address Clarkston Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Lyle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72782

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Edward Freemont Parks.

(a) Residence. No. St. Jacques Spur, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single,

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) January 6th, 1891.

7. AGE: 39. Years; Months: 10.; Days: 15; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska.

PARENTS

10. NAME OF FATHER: Charles Parks.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Alice Mason.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada.

14. Informant: C. C. Parks.
(Address) Culdesac, Idaho.

15. Filed 12-1, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 21st, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 21, 1930

that I last saw him alive on 19

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows: Broncho pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) J. M. Lyle, M. D.

11/23/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jacques Spur, Idaho.

Date of Burial: 11/23/30. 19

20. Undertaker: Brower-Wann Company.

Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72783

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

(No. Whites Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

164

2. FULL NAME Huldah Reed Wilson.

(a) Residence. No. 417 17th, Street. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): May 2nd, 1856.

7. AGE: Years 74. Months 5. Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Albany, Oregon.

PARENTS

10. NAME OF FATHER: James M. Reed.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Hattie Morgan.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Burlington, Iowa.

14. Informant: Wilbur D. Henney.
(Address) Lewiston, Idaho.,

15. Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 21st, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/21-1930, 19, to 11/21-1930, 19

that I last saw her alive on, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Old age.

(duration) 74 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sign & symptoms

(Signed) H. Rouse, M.D., M. D.

11/22/30, 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Walla Walla, Washington. Date of Burial 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

Alley

DO NOT WRITE IN THIS SPACE
State File No. 72781

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No. 96

Primary Registration District No. 1009

Local Registrar's No.

(No. 113 Delsol Lane.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Sarah C. Scott.

(a) Residence. No. 113 Delsol Lane. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 18th, 1858.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.	9.	28.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER -------- Adams.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Winnifred Stofford.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana.

14. Informant J. C. Scott
(Address) Lewiston, Idaho.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 16th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 12, 1930, to Nov 16, 1930 that I last saw h[illegible] alive on Nov 16, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis
Hypertension
Chr. myocarditis
(duration) ? yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Lab

(Signed) Ruepl M. Alley, M. D.

11/18/30., 19.... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	11/18/30. 19

20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72785

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

44 B

2. FULL NAME Hattie A. Olsen

(a) Residence. No. ..... St. Orofino Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Olsen

6. DATE OF BIRTH (month, day and year): July 5 1871

7. AGE: Years 59, Months 4, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Hiram Huntley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Adelia Gray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Walter Olsen
(Address) Orofino Idaho

15. Filed 10/17, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov - 15, 1930 to Nov 16, 1930
that I last saw her alive on Nov 16, 1930
and that death occurred, on the date stated above, at 7 45 A m.
The CAUSE OF DEATH* was as follows:
Chr. myocarditis
..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Findings
(Signed) J. G. [illegible], M. D.
11/17, 1930 (Address) Lewiston Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Orofino Idaho
Date of Burial: 19

20. Undertaker: Brower-Warren Co
Address: Lewiston Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12786

Registration District No. 96
Primary Registration District No. 1209
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Lewiston (No.) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sudie Elizabeth Roe

(a) Residence. No. 1502 - 9th Ave St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jamil Roe.

6. DATE OF BIRTH (month, day and year) Jan 16 - 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS
10. NAME OF FATHER M M. Bashor.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Susan Gant
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant S. E. Roe
(Address) 1502 - 9th Ave

15. Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to Nov 4, 1930
that I last saw her alive on Nov 4, 1930
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Gall Bladder

(duration) ? yrs. ? mos. 2 ds.
CONTRIBUTORY (Secondary) Secondary Anemia.
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Not Known
Did an operation precede death? Yes Date of July 31, 1930
Was there an autopsy? No
What test confirmed diagnosis? Lab exam of Specimen
(Signed) Ralph M. Abby M. D.
Nov 6, 1930 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	11/6 1930
20. Undertaker	Address
Vassar Mortuary Inc	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED NOV 2 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12787

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 49
Primary Registration District No. 2127
Local Registrar's No. 23
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James J Cox
(a) Residence. No. Kamiah - Idaho St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

1110

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Elnora Cox

6. DATE OF BIRTH (month, day and year) 7-26-1873

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher + Trapper
(b) General nature of industry, business, or establishment in which employed (or employer) Ranching + Lo...
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) First Rock Oregon

PARENTS

10. NAME OF FATHER John Cox
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant Ray Randall
(Address)

15. Filed 10/18/30, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12, 1930, to Oct 17, 1930
that I last saw him alive on Oct 17, 1930
and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Perforated Gastric Ulcer

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Peritonitis.
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Oct 12, 1930
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) Ralph M. Alley, M. D.
Nov 21, 1930 (Address) Lewiston, Ida.

19. Place of Burial, Cremation, or Removal Kamiah Ida — Date of Burial 10/19/30
20. Undertaker Kamiah Funeral Home — Address Kamiah

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72788

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas Isaacs
(a) Residence. No. Kamiah Idy St. 119
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Isaacs

6. DATE OF BIRTH (month, day and year) About

7. AGE Years Months Days If LESS than 1 day, hrs. or min.
70 approx

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Diversified
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Near Lewiston Idaho

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant [illegible]
(Address) [illegible]

15. Filed 9/8/30, 19 J. O. Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1930, to Sept. 8, 1930
that I last saw him alive on Sept. 8, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Acute ileo colitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Verbeekmoe, M. D.
, 19 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah #2 Ind. Date of Burial 9-10 1930

20. Undertaker Kamiah Funeral Home Address Kamiah

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

72788

1 PLACE OF DEATH

County Lewis State Idaho Registered No.

Township or Village Kamiah Vicinity or

City No. , St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Isaac

(a) Residence. No. Kamiah, Ida St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	4/4 Nez Perce Indian	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Hannah Ellenwood

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reserve
(State or country) Idaho

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Abel Grant-Laborer
(Address) Lapwai, Ida.

15 Filed 7/10/, 1930 [signature] REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from

, 19, to , 19,

that I last saw h alive on , 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

No physician in attendence reported

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Kamiah Cemetery	Sept 10 1930
20 UNDERTAKER	**ADDRESS**
Geo. W. Trenary	Kooskia

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 96

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72789

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2129
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

101a

2. FULL NAME Harry Hayes

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE Indian
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Hayes

6. DATE OF BIRTH (month, day and year) Nov 1857

7. AGE 73- Years | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Diversified
(c) Name of employer

9. BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS

10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) Kamiah
(State or Country) Idaho
12. MAIDEN NAME OF MOTHER Deborah - (not Known
13. BIRTHPLACE OF MOTHER (city or town) Kamiah
(State or Country) Idaho

14. Informant Mrs Helen Hayes Soukingglass
(Address) Kamiah Ida

15. Filed 4/16, 1930 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7th, 1930, to above, 19..
that I last saw him alive on April 7th, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) [signature], M. D.
April, 1930 (Address) Kamiah, Id

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah Ind #1 | Date of Burial 2/18 1930

20. Undertaker Kamiah General Home | Address Kamiah

RECEIVED DEC 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72790

PLACE OF DEATH
County of Ouida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 45

14B

2. FULL NAME Taliesin Hughes
(a) Residence. No. Sacuaria Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jane Mason Hughes

6. DATE OF BIRTH (month, day and year) July 18-1843

7. AGE: Years 87 | Months 4 | Days 15 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wales

PARENTS
10. NAME OF FATHER: James Hughes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Margaret Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Taliesin Hughes Jr.
(Address) Rt. #1 Malad Ida

15. Filed 11/30, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 28, 1930
that I last saw him alive on Nov. 26, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Blind & deaf.
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings
(Signed) W. P. Gant, M. D.
Nov. 29, 1930 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pleasantview Ida | Date of Burial: Dec-1-1930

20. Undertaker: J. Guy Benson | Address: Malad Ida

RECEIVED DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72791

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

48B

2. FULL NAME Amelia B. Bush
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Robt. T. Bush

6. DATE OF BIRTH (month, day and year) Oct-16-1842

7. AGE Years 88 Months Days 30 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Gosport England

PARENTS
10. NAME OF FATHER James Bailey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Ann Brockway
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant ✓ Robert T. Bush Jr.
(Address) Malad Ida

15. Filed 11/30, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1926 to Nov. 14, 1930
that I last saw her alive on Nov. 14, 1930
and that death occurred, on the date stated above, at 2 P. m.
The CAUSE OF DEATH* was as follows:
Myocarditis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broken arm

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? 1st. findings
(Signed) V. P. Grant, M. D.
Nov. 18, 1930 (Address) Malad, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Malad Ida
Date of Burial Nov. 18 1930

20. Undertaker J. Guy Benson
Address Malad Ida

RECEIVED DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72792

PLACE OF DEATH
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 43

10 ~~107~~

2. FULL NAME Delpha Jones
(a) Residence. No. Malad Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 26-1921

7. AGE Years 9 Months 6 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Malad Ida

PARENTS
10. NAME OF FATHER Hugh L. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Malad Ida
12. MAIDEN NAME OF MOTHER Millie Bloxham
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Downey Ida

14. Informant Hugh L. Jones
(Address) R.F.D. Malad Ida

15. Filed 11-30, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 13, 1930
that I last saw her alive on Nov. 13, 1930
and that death occurred, on the date stated above, at 1.30 P.m.
The CAUSE OF DEATH* was as follows: Membranous Croupe
(duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Kerns, M. D.
11-13, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Malad Idaho
Date of Burial: Nov 15 1930

20. Undertaker: J. Guy Benson
Address: Malad Ida

RECEIVED DEC 4

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12793

PLACE OF DEATH
County of Oneida
City of Malad.

Registration District No. 76
Primary Registration District No. 2069

Local Registrar's No. 42

(No.) 10
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gordon Dean Peterson

(a) Residence. No. Main St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 21. 1925

7. AGE	Years	Months	Days	If LESS than 1 day,
	5	1	21	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Salt Lake (State or country) Utah

PARENTS

10. NAME OF FATHER Abraham Peterson
11. BIRTHPLACE OF FATHER (city or town) Helen City (State or Country) Utah
12. MAIDEN NAME OF MOTHER Margaret Camps
13. BIRTHPLACE OF MOTHER (city or town) Pleasantview (State or Country) Idaho

14. Informant Margaret Camp Peterson
(Address) Malad Idaho

15. Filed 11/30, 1930 J. M. Kerns Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 10 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1930, to Nov 10 1930, that I last saw h alive on , 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. M. Kerns M. D.
11/12, 1930 (Address) Malad Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasantview Ida	Nov. 12 1930

20. Undertaker	Address
J. Leroy Benson	Malad Ida

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72794

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 51
Primary Registration District No. 2130 Local Registrar's No. 5
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

96

2. FULL NAME Bell Hill

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Jas N Hill

6. DATE OF BIRTH (month, day and year) Mar 15 1874

7. AGE Years 56 Months 6 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS
10. NAME OF FATHER Roderick McRae
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nova Scotia
12. MAIDEN NAME OF MOTHER Catherine McGurrie
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nova Scotia

14. Informant (Address) Iona Hill Birdsall Fruitland Ida

15. Filed Oct 9, 1930 Mrs Wm T. Drysdale Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 6 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4, 1930, to Oct 6, 1930
that I last saw her alive on Oct 6, 1930
and that death occurred, on the date stated above, at 8:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Generalized Deforming arthritis
(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion & absorption from bed sores
(duration) yrs. many mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? clinical evidence
(Signed) Wm T. Drysdale, M. D.
10-8, 1930 (Address) New Plymouth Ida

19. Place of Burial, Cremation, or Removal Ontario Ore
Date of Burial Oct 8 1930

20. Undertaker Peterson Furn Co J. H. Adams Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72795

PLACE OF DEATH

County of Power

City of American Falls

Registration District No. 25

Primary Registration District No. 2072

(No. Bethony Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2[illegible]

92

2. FULL NAME Mary Ruff

(a) Residence. No. North of American Falls, nine miles St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Gottfread Ruff

6. DATE OF BIRTH (month, day and year): March 31 1881

7. AGE: Years 49 Months 7 Days 7 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): South Russia

PARENTS

10. NAME OF FATHER: Fred Knolden

11. BIRTHPLACE OF FATHER (city or town) (State or Country): RUssia

12. MAIDEN NAME OF MOTHER: Christene Kroll

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14. Informant: Gottfried Ruff
(Address) Aberdeen, Idaho

15. Filed Nov. 19, 1930. Emerson Nott Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 8th (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 8, 1930

that I last saw her alive on Nov 8, 1930

and that death occurred, on the date stated above, at 9:20 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary Embolism 5 min

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Oct 31-1930

Was there an autopsy? No

What test confirmed diagnosis? Laboratory work -

(Signed) M. C. MacKinnon, M. D.

Nov 10, 1930 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: American Falls Cemetary — Date of Burial 11/12/30 19

20. Undertaker: A. W. Davis — Address: American Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72796

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 25

Primary Registration District No. 2072

Local Registrar's No. 26

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

142

2. FULL NAME Naoji Akiyama

(a) Residence. No. Pocatello, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japaneese Whi

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 17 1901

7. AGE: Years 28 | Months 3 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Japan

PARENTS

10. NAME OF FATHER: C. Akiyama

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Japan

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Japan

14. Informant: J. Akiyama

(Address) Pocatello, R.F.D.1

15. Filed Nov. 4, 1930. Guerin Noth Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Was Drowned in Snake River July 20th/30 Body recovered Nov 3rd, 1930.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? A W Davis Coroner

(Signed) ....., M. D.

11/3/30, 19.... (Address) American Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Pocatello, Cemetary

Date of Burial: 11/4/30 19

20. Undertaker: A W Davis

Address: Am Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72797

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 102

49

2. FULL NAME Bert O. Lightner

(a) Residence. No. Enaville Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Sarah Lightner

6. DATE OF BIRTH (month, day and year) Mar 12-1875

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min
55	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS

10. NAME OF FATHER: Oscar Lightner
11. BIRTHPLACE OF FATHER (city or town) (State or Country): do not know
12. MAIDEN NAME OF MOTHER: Martha Runner
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): don't know

14. Informant: Sarah Lightner
(Address): Enaville Idaho

15. Filed Nov 5, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930 to Oct 31, 1930
that I last saw him alive on Oct 30, 1930
and that death occurred, on the date stated above, at 7 P m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos. from Hinton ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Exam
(Signed) Max T. Quigley, M.D.
11-4-30, 19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kingston Idaho
Date of Burial: Nov. 5 1930

20. Undertaker: R. L. Stout
Address: Kellogg Idaho

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72798

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 101

4

2. FULL NAME Marcus Pearson
(a) Residence. No. King St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3-1924

7. AGE Years 6 Months 9 Days 27 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER Adolph Pearson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Hannah Carlson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Adolph Pearson
(Address) Wallace, Idaho

15. Filed Nov 2, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Oct 31, 1930
that I last saw him alive on Oct 31, 1930
and that death occurred, on the date stated above, at 10 20 A m.
The CAUSE OF DEATH* was as follows:
Scarlet Fever

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? physical examination
(Signed) R. Merrick, M. D.
Oct 31, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho
Date of Burial Nov 2 1930

20. Undertaker J. A. Bower Ward Und. Co.
Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72799

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 100

2. FULL NAME Roscoe Martin Fisher

(a) Residence. No. Mullan, Ida St. 1014 Mullan, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 8 - 1907

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	8	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer) Miner
(c) Name of employer Morning Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Ontario Ore

PARENTS

10. NAME OF FATHER Guy L. Fisher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cove Ore.
12. MAIDEN NAME OF MOTHER Lula Martin.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Cove Ore

14. Informant Leslie Fisher
(Address) Mullan, Ida.

15. Filed Oct 30, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1930, to Oct 26, 1930
that I last saw h ims alive on Oct 26, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Hypopituitary secretion
(duration) 17 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Mullan, Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? physical examination
(Signed) Paul R. Ellis, M. D.
Oct 27, 1930 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Cedar Hill Cem. Wallace Ida. Date of Burial Oct 30 1930
20. Undertaker J. A. Lever Address
Ward Und Co. Wallace, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 99
(No. Stevens Hotel, Mullan Ida
(If death occurred in a hospital or institution, give its name instead of street and number.)

174

2. FULL NAME Allen Stevens

(a) Residence. No. Mullan, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married
5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Norman Stevens
6. DATE OF BIRTH (month, day and year) Aug 29- 1886.
7. AGE: Years 44 | Months 1 | Days 23 | If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mississippi

PARENTS
10. NAME OF FATHER Van Hendrix
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Martha Bassett
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Aurora, Missouri

14. Informant Norman Stevens, (Address) Mullan Idaho.
15. Filed Oct 25, 1930. F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 22 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 22, 1930
that I last saw her alive on Oct 22, 1930
and that death occurred, on the date stated above, at 11:40 P.m.
The CAUSE OF DEATH* was as follows:
Acute nephritis
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F W Rolf, M. D.
Oct 23, 1930 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan, Idaho.	Oct. 25 1930
20. Undertaker	Address
Bruce G. Morstad	Wallace Ida.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72801

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 101
Local Registrar's No. 98
(No. Mace Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leo Phillip Eschbach 131

(a) Residence. No. Mace Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 12 1916

7. AGE: Years 14 Months 6 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wallace Idaho

PARENTS
10. NAME OF FATHER: Phillip Eschbach
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mayence Germany
12. MAIDEN NAME OF MOTHER: Emma Naymaster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minnesota

14. Informant: Phillip Eschbach
(Address) Mace, Idaho

15. Filed Oct 24, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Hemaphysis
..... (duration) ..... yrs. ..... mos. Few min
CONTRIBUTORY (Secondary) Pneumonia
..... (duration) ..... yrs. ..... mos. 3-4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
10/24 (Signed) H. S. Mowery Corone
1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Ida
Date of Burial: Oct 24 1930

20. Undertaker: B. G. Worstell
Address: Wallace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. M. 1-16-13

RECEIVED NOV 25 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. ..... St.)

File No. 72802

Registered No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ceal Wvesta

CEAL WVESTA

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. May (Month) 25 (Day) 1867 (Year)

7. AGE 63 Yrs. 4 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Axel Wvesta

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Alga Wvesta

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. M. Rogers

(Address) Shoshone County Infirmary

15. Filed Oct 21 1930 F. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH 10 (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-18- 1930, to 10-19- 1930, that I last saw him alive on 10-18- 1930, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Decompensation
Chr. Valv. Heart

(Duration) ..... Yrs. ..... mos. 1 days ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.

10/22/1930 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 1 days. In the State 20 yrs. — mos. — days

Where was disease contracted if not at place of death?.....

Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL Kellogg, Ida

DATE OF BURIAL Oct 21 1930

20. UNDERTAKER M. C. Thurkill

ADDRESS Kellogg, Ida

SYMS - YORK CO., PTRS. & BDRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH NOV 25 1930

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011

(No. ....., ... St.)

File No. 72803

Registered No. 96

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Bellemon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1856 (Year)

7. AGE 74 Yrs. 0 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Quebec Canada

10. NAME OF FATHER Edward Bellemon

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. M. Rogers

(Address) Shoshone County Infirmary

15. Filed Oct 17 1930 J. L. Quigley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-19th 1928, to 10-15- 1930, that I last saw him alive on 10-14- 1930, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma (Years)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Shock - and increased difficulty in breathing - by severing trachea in suicidal

(Duration) attempt mos. 4 ds.

(Signed) James R Bean M. D.

10/22 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 11 mos. 27 days In the State 42 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood Cemetery

DATE OF BURIAL: 10/17/30 191

20. UNDERTAKER: M. C. Thornhill, Kellogg, Ida.

ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72804

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

47

2. FULL NAME Tom Svetich
(a) Residence. No. Kellogg, Idaho St. Kellogg, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Abord 38 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Jack Waite Mng. Co

9. BIRTHPLACE (city or town) (State or country) Jugo Slavia.

PARENTS
10. NAME OF FATHER Dan Svetich
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Jugo Slavia.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Jugo Slavia.

14. Informant Joe Lemich
(Address) Kellogg, Ida

15. Filed Oct 20, 1930 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1930, to Oct 14, 1930
that I last saw him alive on Oct. 14th, 1930
and that death occurred, on the date stated above, at 6.30 a m.
The CAUSE OF DEATH* was as follows:
Chronic adhesive pericarditis
(duration) yrs. 4 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Murray, Ida.
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? X-ray, autopsy
(Signed) Paul Mollis, M. D.
Oct 15, 1930 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Oct 20 1930

20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72805

PLACE OF DEATH
County of Ada
City of Eagle
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 94
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Clara Jane Robinson

(a) Residence. No. Eagle - Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb - 5 - 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	76	8	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS
10. NAME OF FATHER [illegible]
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs Esther Robinson
(Address) Eagle

15. Filed Oct 16, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:
Myocarditis Chron. apoplexy Hemorrhage
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia.
(duration) 2 days yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R. A. Morrell, M. D.
10/15, 19 30 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace	Oct - 16 1930
20. Undertaker Bruce G. Mordell.	Address Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED NOV 25 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72806

PLACE OF DEATH
County of Shoshone
City of Wallace.

Registration District No. 70
Primary Registration District No. 10 N
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 93

180a

2. FULL NAME Charles M Baillie
(a) Residence. No. Wallace Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years 65. Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Man.
(b) General nature of industry, business, or establishment in which employed (or employer) Retired.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Pictou Nova Scotia.

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known.

14. Informant Friends.
(Address)
15. Filed Oct 13, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 3 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw him alive on Oct 3, 1930
and that death occurred, on the date stated above, at 3:30 P m.
The CAUSE OF DEATH* was as follows: Struck by O.W.R.&N. Passenger Train Severing Head at Neck
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. Mowery Coroner
10/7, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. Date of Burial Oct 13 1930
20. Undertaker J. A. Bever Ward Und Co. Address Wallace, Idaho

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72807

PLACE OF DEATH
County of Shoshone
City of Wardner

Registration District No. 123
Primary Registration District No. 2201
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

31

2. FULL NAME Ike Kenty
(a) Residence. No. Wardner, Idaho St. Wardner, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Agnes Kenty

6. DATE OF BIRTH (month, day and year) Feb 27 - 1867

7. AGE 63 Years | Months 9 | Days 0 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mrs Berry
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Canada

14. Informant (Address) Mrs Agnes Kenty Wardner, Idaho

15. Filed Nov. 28, 1930 Mrs. Helen McBride Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th, 1930, to Nov 27, 1930
that I last saw him alive on Nov 27th, 1930
and that death occurred, on the date stated above, at 5 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology
(Signed) W C Lindsay, M. D.
11/28, 1930 (Address) W C Lindsay.

19. Place of Burial, Cremation, or Removal Wallace, Idaho. | Date of Burial Nov. 30 1930

20. Undertaker J. A. Boyer Ward Und Co. | Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72808

PLACE OF DEATH
County of Shoshone
City of Kingston

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 62

179

2. FULL NAME ~~Ronald~~ Ronald Roy Edson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3 1928

7. AGE: 2 Years | Months: 3 | Days: 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cataldo Idaho

PARENTS

10. NAME OF FATHER James Edson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nebraska
12. MAIDEN NAME OF MOTHER Blanche Van
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Oklahoma

14. Informant James Edson
(Address) Kingston Idaho

15. Filed Nov. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-17-, 1930, to 11-17-, 1930
that I last saw him alive on 11-17-, 1930
and that death occurred, on the date stated above, at 3:30 p. m.
The CAUSE OF DEATH* was as follows:
Severe generalized skin burn.
..... (duration) ..... yrs. ..... mos. 2 hours ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) T. W. Laraway, M. D.
11-18-, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Newport Wash | Date of Burial: Nov. 19 1930

20. Undertaker: M C Sharohee | Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 5 1930

PLACE OF DEATH

County of Shoshone

City of Kellogg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. 2201

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72809

Local Registrar's No. 61

164

2. FULL NAME David Huffer Barnhart

(a) Residence. No. 513 Main St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 32 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza Jane Barnhart (deceased)

6. DATE OF BIRTH (month, day and year): Oct 24 - 1846

7. AGE: 84 Years, Months, Days 21. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter (retired)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Newburn, Ind.

PARENTS

10. NAME OF FATHER: Andrew Jackson Barnhart

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Funkhouser

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ind.

14. Informant: Mrs Dea Barnhart
(Address) Box 967 Kellogg Ida.

15. Filed Nov 28, 1930 Mrs. [illegible] McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1930, to Nov 15, 1930 that I last saw him alive on Nov 12, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Old age. Chronic myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) W C Lindsay, M. D.

11/26, 1930 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: ~~[illegible]~~ Greenwood — Date of Burial: Nov 19 1930

20. Undertaker: ~~Keeley Jack~~ M. C. Thornhill — Address: Keeley Ida.

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72810

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 60

205-B

2. FULL NAME Marguret Maraino
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug 16-1930
7. AGE Years | Months 2 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Kellogg Idaho

PARENTS
10. NAME OF FATHER Jasinto Maraino
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico
12. MAIDEN NAME OF MOTHER Natibidad Diosdado
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Jasinto Maraino.
(Address) Kellogg Idaho
15. Filed Nov. 28, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 11 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw her alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH was as follows: Found dead in bed cause unknown
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) None
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) H. C. Mowery Co. M.D.
11/11, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Idaho | Date of Burial: 11/12 1930
20. Undertaker: R. L. Stout | Address: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72811

PLACE OF DEATH

County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 59
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Georgia Alice Harrah

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 3, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kellogg, Ida.

PARENTS

10. NAME OF FATHER M. J. Harrah
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon
12. MAIDEN NAME OF MOTHER Talbott [redacted]
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant M. J. Harrah
(Address)

15. Filed Nov. 28, 1930 Mrs. Helen [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 28, 1930, to Nov 11 1930
that I last saw her alive on Nov 11 1930
and that death occurred, on the date stated above, at 6 p. m.
The CAUSE OF DEATH* was as follows:

Cachexia

(duration) yrs. 3/4 mos. ds.
CONTRIBUTORY (Secondary) Pneumonia x Cholera Infantum
(duration) yrs. 1/2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical.
(Signed) [redacted] M. D.
11-12-1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Opportunity, Wash.	11/13/30
20. Undertaker M C Thornhill	Address Kellogg Ida

RECEIVED DEC 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72812

PLACE OF DEATH
County Shoshone
City of Kellogg.

Registration District No. 123
Primary Registration District No. 3201
Local Registrar's No. 5-8
(No. ..... Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME William Henry Purdy

(a) Residence. No. ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Edith Purdy.

6. DATE OF BIRTH (month, day and year) Dec 2 - 1882.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	11	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Grand Forks N. D.

PARENTS

10. NAME OF FATHER Robert Purdy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario Canada
12. MAIDEN NAME OF MOTHER Mary Ellen O'Brien
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Appleton Ontario

14. Informant Edith Purdy
(Address) Kellogg

15. Filed Nov. 28, 1930. Mrs. Helen B. Bridges
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st, 1930, to Nov 6th, 1930, that I last saw ~~him~~ alive on Nov 6th, 1930, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of face -
..... (duration) yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms Lab. Tests
(Signed) W. G. Lundgren, M. D.
11/8, 1930. (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace Ida	11/9 1930
20. Undertaker	Address
P. L. Stark	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72813

PLACE OF DEATH

County of Teton
City of Victor Ida

Registration District No. 77
Primary Registration District No. 2176
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 10

24

2. FULL NAME Mildred Sinclair
(a) Residence. No. Victor Ida. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) May 9 - 1917

7. AGE Years 13 Months May Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Victor Ida.

PARENTS
10. NAME OF FATHER Jesse Sinclair
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake Utah.
12. MAIDEN NAME OF MOTHER Ellen Pitts
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Jesse Sinclair
(Address) Victor, Idaho.

15. Filed 12-3-, 1930 Martha Marker
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13, 1930, to 11-13, 1930
that I last saw her alive on 11-13, 1930
and that death occurred, on the date stated above, at 11 45 P. m.
The CAUSE OF DEATH* was as follows:
acute Dilatation of heart
..... (duration) Sudden yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebrospinal meningitis
..... (duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. F. Parkinson M. D.
....., 19.... (Address) Driggs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Victor, Idaho
Date of Burial: 11-14-1930

20. Undertaker: —
Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72811

PLACE OF DEATH
County of Teton
City of Tetonia

Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 10
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

188 e

2. FULL NAME Edgar L. Wood
(a) Residence. No. Tetonia R.D. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) June 2 - 1911

7. AGE Years 19 Months 5 Days 17 If LESS than 1 day, ——— hrs. or ——— min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bates Ida

PARENTS
10. NAME OF FATHER Leo Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bates Ida
12. MAIDEN NAME OF MOTHER Verlie Buxton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Smithfield Ut.

14. Informant (Address) Leo Wood Tetonia Ida

15. Filed 11-20- 1930 Martha Marker Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-17, 1930, to 11-17, 1930
that I last saw him alive on 11-17, 1930
and that death occurred, on the date stated above, at 6 15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto accident.
Pressure on spinal cord + circulation.
Sudden.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of axis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. S. Parkinson, M. D.
11-18, 1930 (Address) Driggs Ida

19. Place of Burial, Cremation, or Removal Bates Cemetery
Date of Burial 11-21- 1930

20. Undertaker Vern J. Keller
Address Rexburg, Idaho.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72815

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Teton

City of

Registration District No. 77

Primary Registration District No. 2176 Local Registrar's No. 12

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. **FULL NAME** Sarah A. M. Burnside

(a) Residence. No. Chapin, Idaho St.
(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of A. L. Burnside

6. DATE OF BIRTH (month, day and year) Feb. 14, 1877

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	10	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Newstead, (State or country) England

PARENTS

10. NAME OF FATHER Mr. Mauttishaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER ~~Mrs Bacon~~ Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know

14. Informant Alice Burnside
(Address)

15. Filed 12-3-, 1930 Martha Marker Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/15, 1930, to 11/22, 1930
that I last saw her alive on 11/22, 1930
and that death occurred, on the date stated above, at 11:45 P. m.

* *State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia - weakened by extension of pneumonic process

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. T. C. Tarr, M. D.

11/23, 1930. (Address) Driggs, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Darby, Idaho.	11-25-1930

20. Undertaker W. W. Hansen & Anthony Address Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72816

PLACE OF DEATH
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 2087
(No.) Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number.)

167

2. FULL NAME Kenneth O. Farrell

(a) Residence. No. Burke St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, 15 hrs. or min.
—	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Burke Idaho

PARENTS

10. NAME OF FATHER: Clyde Farrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Ora Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ore

14. Informant: Mrs. Geo. Ogg
(Address) Burke Ida.

15. Filed 11-25, 1930 J. T. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
8 P.M. 24 Nov, 1930, to 4 A.M. 25 Nov, 1930
that I last saw he alive on 25 Nov, 1930
and that death occurred, on the date stated above, at 4 a.m.
The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) J. W. MacMannes M. D.
26-11, 1930 (Address) Burke, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burke Cemetery	11/25 1930
20. Undertaker	Address
Wardle & Ruggles	Burke Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DEC 4 1930

DO NOT WRITE IN THIS SPACE
State File No. 72811

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. 39
Primary Registration District No. 2087
(No.)
Local Registrar's No. 111a

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Virginia Herman

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of H. W. Herman

6. DATE OF BIRTH (month, day and year) March 22 - 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion Virginia

PARENTS

10. NAME OF FATHER Wm H. McDonald
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Ellen Beaty
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Virginia

14. Informant (Address) H W Herman

15. Filed Nov. 14, 1930 J H Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
Nov. 1, 1930, to Nov. 12, 1930,
that I last saw h.r alive on Nov. 12, 1930,
and that death occurred, on the date stated above, at 9:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Ruptured Gastric Ulcer.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical

(Signed) J. H. Murphy, M. D.
Nov 14, 1930 (Address) Burley Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida.	11/15 1930
20. Undertaker L. Johnson	Address Burley

RECEIVED DEC 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72818

PLACE OF DEATH
County of Twin Falls
City of Castleford

Registration District No. 39
Primary Registration District No. 2087
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

162

2. FULL NAME Daty Burgess
(a) Residence. No. Castleford Ida. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 8-1930

7. AGE — Years — Months — Days — If LESS than 1 day, 7½ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Castleford

PARENTS
10. NAME OF FATHER J. S. Burgess
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Clara Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn

14. Informant J. S. Burgess
(Address) Castleford Ida

15. Filed 11-13, 1930. V. J. F. Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth, 19..., to 5 A.M. 9-Nov, 1930
that I last saw h..... alive on 8-Nov-, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows:
Atalectasis

8 hrs. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? failure to inflate
(Signed) F. W. Mac Mauns, M. D.
....., 19.. (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Buhl Cemetery — Date of Burial 11/10 1930

20. Undertaker Newell D. Rugg — Address Buhl Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D DEC 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72819

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Twin Falls County Hospital
Registration District No. 39
Primary Registration District No. 2017 Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvah C. Luce

(a) Residence. No. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Luce.

6. DATE OF BIRTH (month, day and year) June 8 - 1861

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER — Luce

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Don't Know

14. Informant Homer A. Luce
(Address) Burley, Ida.

15. Filed 11-7, 1930 J. H. Markley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-21, 1930, to 11-3, 1930 that I last saw him alive on 11-2, 1930 and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Struck by auto-contusion abrasions face. Left leg-compound infected.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. Russell Weaver, M. D.
11-7, 1930 (Address) Twin Falls Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	11-5 1930
20. Undertaker L. J. Johnson	Address Burley

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 19 1930

DO NOT WRITE IN THIS SPACE
State File No. 72829

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2117 Local Registrar's No. 26
(No. 1013)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Joseph Allen Showmaker

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wht	Married

5a. If married, widowed, or divorced
HUSBAND of (~~or WIFE of~~) Arter Showmaker

6. DATE OF BIRTH (month, day and year) Apr 7 — 1872

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Ohio

PARENTS

10. NAME OF FATHER Andrew J Showmaker

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Martha P. Cox

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) Alabama

14. Informant Arter Showmaker
(Address) Weiser Idaho

15. Filed Dec 22, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Dec 1, 1930
that I last saw him alive on Nov 30, 1930
and that death occurred, on the date stated above, at 10 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Debility from Paralysis

(duration) 2 yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) W. O. Marshall, M. D.
Dec 2, 1930 (Address) Weiser

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	12 - 3 - 1930
20. Undertaker L. C. Northam	Address Weiser Ida

RECEIVED DEC 10 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72823

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 25
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Verlmier

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wht	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct - 13 - 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	1	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Stone Mason
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Lott. Verlmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Nancy E. Vice
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indeana

14. Informant A. W. Verlmier
(Address) Weiser Idaho

15. Filed Dec. 31, 1930 W. R. Hamiltow Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 3 P.M, 1930, to Nov 26 11 P.M, 1930
that I last saw him alive on Nov 26, 1930
and that death occurred, on the date stated above, at 11 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
obstruction of bowels, exact diagnosis not made - not in condition to operate
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm Waterhouse, M. D.
Nov 27, 1930. (Address) Weiser Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Pleasant Cemetery	Nov 29 1930
20. Undertaker L. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MHM

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72822

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 66
Primary Registration District No. 1010 Local Registrar's No. 24
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

H4

2. FULL NAME Alexander Watson

(a) Residence. No. 426 E Comm St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wht	Widowed

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 12 1847

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Hamilton Ontario
(State or country) Canada

PARENTS

10. NAME OF FATHER Alexander Watson
11. BIRTHPLACE OF FATHER (city or town) Elmira
(State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Coulter
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Scotland

14. Informant Mrs Waldo Taylor
(Address) Weiser Ida

15. Filed Dec 1, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Jan - 1 - 30, 19..., to Nov - 21, 1930
that I last saw h[illegible] alive on Nov. 21 - 30, 19...
and that death occurred, on the date stated above, at 10 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
carcinoma of the stomach

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) C. C Canaut, M. D.
Nov - 22 - 30, 19... (Address) Weiser Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	Nov 23 1930
20. Undertaker	Address
L. C. Northam	Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72823

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010 Local Registrar's No. 23
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

118B

2. FULL NAME Carl Albrecht Sr.
(a) Residence. No. 906-E-Liberty St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Annie Albrecht

6. DATE OF BIRTH (month, day and year) Feb 27-1864

7. AGE Years 67 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mason
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER George Albrecht
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Annie Albrecht 906-E Liberty St. Weiser Idaho

15. Filed Nov. 19th, 1930 W. R. Hamilton M.H.M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 16 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 16, 1930
that I last saw him alive on Nov. 14, 1930
and that death occurred, on the date stated above, at 9 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
fecal obstruction
2 fowls followed with
slow intestinal Hemorrage.
(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) asthma. (Bronchial)
(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. A. Schmid M. D.
Nov. 17, 1930 (Address) Weiser I.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery
Date of Burial Nov. 17 1930

20. Undertaker L. C. Northam
Address Weiser Ida

m.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72824

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 22

92

2. FULL NAME Della M Davis

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John W. Davis

6. DATE OF BIRTH (month, day and year) Dec 20, 1883

7. AGE 46 Years | Months 10 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weiser Idaho

PARENTS
10. NAME OF FATHER W R. Shaw
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Lena Madison
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Nevada

14. Informant John W. Davis
(Address) Weiser - Idaho

15. Filed Nov. 19th, 1930 W R Hamilton Registrar
M H M

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4, 1930, to Nov 4, 1930
that I last ~~saw her alive on~~ not seen alive, 19.....
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Cardiac Thrombosis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) W H Marshall, M. D.
Nov 17, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial 11-6-1930

20. Undertaker L. C. Northam | Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72825

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 2112

Local Registrar's No. 21

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

16 H

2. FULL NAME Eli Richards

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wht
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Alice Richards

6. DATE OF BIRTH (month, day and year): July 15 1846

7. AGE: Years 84 | Months 3 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Wales Eng.

PARENTS

10. NAME OF FATHER: Wm Richards
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wales. Eng.
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales. Eng

14. Informant: W D. Richards
(Address): Weiser Idaho

15. Filed Nov. 7, 1930. W. R. Hamilton Registrar
M & M

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 6 10 a.m.
The CAUSE OF DEATH* was as follows: Senility died before medical assistance arrived

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....

(Signed) L. C. Northam Coroner M. D.
Nov 7, 1930 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mound Idaho	11 - 1930
20. Undertaker	**Address**
L. C. Northam	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72826

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 20

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Elizabeth Morehead

90

(a) Residence. No. 603 East Com St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of J. M. Morehead

6. DATE OF BIRTH (month, day and year) Feb. 16.

7. AGE Years 62 Months 8 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS
10. NAME OF FATHER John McRoberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Ruth Mackey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Mrs C. C. Hargrove
(Address) Weiser Idaho

15. Filed Nov 5, 1930 W. R. Hamilton M.H.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930, to Oct 19, 1930
that I last saw her alive on Oct 19, 1930
and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows:
Cardiac Debility
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Degenerated Lipomata
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. W. Marshall, M. D.
Oct 25, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery — Date of Burial 10-22-1930

20. Undertaker L. C. Northam — Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

26

RECEIVED DEC 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72827

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

129

2. FULL NAME Wilford L. Woodruff.

(a) Residence. No. 455 W. Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	divorced

5a. If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Gertrude Woodruff

6. DATE OF BIRTH (month, day and year) Aug 3 - 1883

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	2	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Vernal Utah

PARENTS

10. NAME OF FATHER David Woodruff

11. BIRTHPLACE OF FATHER (city or town) (State or Country) ~~Provo Utah~~ Provo Utah

12. MAIDEN NAME OF MOTHER Arabelle Hatch

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Mrs H.C. Caldwell
(Address) Weiser. Idaho

15. Filed Nov. 5, 1930 W. R. Hamilton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Oct 28, 1930
that I last saw him alive on Oct 22, 1930
and that death occurred, on the date stated above, at 11.30 a. m.
The CAUSE OF DEATH* was as follows:

Bright's Disease
Chronic nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) W. W. Marshall M. D.
Oct 25, 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	Oct 26 1930
20. Undertaker L. C. Northam	Address Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 3 1930

PLACE OF DEATH

County of Washington

City of Weiser

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72828

Local Registrar's No. 18

2. FULL NAME Williams Clemet Attebery

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W M	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Attebery

6. DATE OF BIRTH (month, day and year) Nov. 16. 1850

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	11	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Thomas Attebery

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Henry Attebery

(Address) Weiser Idaho

15. Filed Nov. 5 1930 W. R. Hamilton Registrar

(M H W)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1930 to Oct. 19. 1930

that I last saw ~~him~~ alive on Oct 19. 1930

and that death occurred, on the date stated above, at 12.9. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W A Mahaffie, M. D.

Oct 28 1930 (Address) Weiser

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	10-21- 1930
20. Undertaker L. B. Northam	Address Weiser Ida

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72829

PLACE OF DEATH
County of Elmore
City of Featherville
Precinct

Registration District No. 34
Primary Registration District No. 2020
Local Registrar's No. 12
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Perry Edwin Phelps 90
(a) Residence. No. Featherville Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Flora Phelps.

6. DATE OF BIRTH (month, day and year) 4-10-1863

7. AGE Years 67 Months 6 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer) Retired.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS
10. NAME OF FATHER Mark Phelps.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York.
12. MAIDEN NAME OF MOTHER Flora L. Gorvey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Neb.

14. Informant Timothy Phelps
(Address) Pine Ida

15. Filed Nov 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 - 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10 A. m.
The CAUSE OF DEATH* was as follows:
Heart attack - Stroke
4th Stroke
Has had High blood pressure (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. S. Zacher Coroner Elmore County, M. D.
11-3-, 1930 (Address) Mt. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Canyon Creek Ida. Date of Burial 11/1 1930

20. Undertaker G. S. Zacher. Address Mt. Home.

...WITH UNFADING INK—THIS IS A PERMANENT RECORD
...information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
...CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
...is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 1 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72830

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 34
Primary Registration District No. 2020

Local Registrar's No. 13

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Felix

(a) Residence. No. Transient St. 170
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Mexican	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep shearer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) —

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant G. S. Zacher.
(Address) Mt. Home Ida.

15. Filed Nov 3, 1930 A. H. Andrews Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) — 29 (Day) — 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on About, 19...
and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:
Gun Wound in head, Suicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) G. S. Zacher Coroner Elmore Co. M. D.
11/3, 1930 (Address) Mt. Home Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home Ida.	11-5 1930

20. Undertaker G. S. Zacher. Address Mt. Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 11 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72831

County of Elmore

Registration District No. 34

City of Mt. Home Ida.

Primary Registration District No. 2020

Local Registrar's No. 14

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Henry Brumley. 90

(a) Residence. No. Mt. Home Ida St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 2-15-1858

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	7	10	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Railroad Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Texas.

PARENTS

10. NAME OF FATHER James Brumley.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Lona Sullivan

(Address) Mt. Home Ida.

15. Filed Dec 2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 25 1930

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-17-, 1930, to 9-25-, 1930

that I last saw him alive on 9-24-, 1930

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation and Aortic - Stenosis of Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F E Logan, M. D.

9-25-, 1930 (Address) Mtn. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home Ida.	9-27 1930
20. Undertaker G. S. Zacher	Address Mt. Home Ida.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72832

PLACE OF DEATH
County of Elmore
City of Mt. Home, Ida

Registration District No. 34
Primary Registration District No. 2020

Local Registrar's No. 15

(No.) 744
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wiel S. Stimson

(a) Residence. No. Mt. Home, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Martha Stimson

6. DATE OF BIRTH (month, day and year) Sept 15-1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	2	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER William Stimson.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Rogers.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Martha Stimson
(Address) Mt. Home, Ida.

15. Filed Dec 2, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) – 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to 11-20-, 1930
that I last saw him alive on 11-14-1930
and that death occurred, on the date stated above, at 10 5 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. E. Evans, M. D.
11-24-, 1930 (Address) Mt. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home, Ida.	11/22 1930
20. Undertaker G. L. Barker.	Address Mt. Home Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72833

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 84
Primary Registration District No. 2020
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 16

129

2. FULL NAME George Romine
(a) Residence. No. Mt. Home, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Unknown.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ——
6. DATE OF BIRTH (month, day and year) 1849
7. AGE Years 81 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Unknown.

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Jennie Casey
(Address) Mt. Home Idaho.
15. Filed Dec 2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 - 20 - 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 10 - 11 -, 1930, to 11 - 20 -, 1930
that I last saw him alive on 11 - 19 -, 1930
and that death occurred, on the date stated above, at 5.20 P m.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. E. Evans, M. D.
11-24-, 1930 (Address) Mt. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mt. Home Ida. Date of Burial 11-21 1930
20. Undertaker G. S. Zacher Address Mt. Home Ida.

...—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72834

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 34
Primary Registration District No. 2020
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 17

2. FULL NAME Taylor Lewis Bailey 90
(a) Residence. No. Mt. Home Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Divorced
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): 9-19-1869
7. AGE: Years 61, Months 2, Days 8; If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: none
9. BIRTHPLACE (city or town) (State or country): Iowa
PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): ✓
14. Informant: John Hoffman
(Address) Mt. Home Ida.
15. Filed Dec 2, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) - 27 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 11-26-, 1930, to 11-27-, 1930
that I last saw him alive on 11-26-, 1930
and that death occurred, on the date stated above, at 7.10 A. m.
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation of Heart, with Enlargement
(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. E. Evans, M. D.
11-28-, 1930 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Oakville Iowa
Date of Burial: 11-29 1930
20. Undertaker: G. S. Zacher
Address: Mt. Home Ida.

...E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

...RITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72835

PLACE OF DEATH
County of Nez Perce
City of Jacques Spur
Registration District No. 96
Primary Registration District No. 1009
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Mrs Bozarth

(a) Residence. No. Jacques Spur – Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. (Single) Married, Widowed, or Divorced (write the word): Married.

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: Elizabeth Bozarth.

6. DATE OF BIRTH (month, day and year): Feb. 9 - 1867

7. AGE: Years 63 | Months 9 | Days 2 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Mo.

PARENTS

10. NAME OF FATHER: Thos. Bozarth
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Rachel Ryle
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ky

14. Informant: Mrs Elizabeth Bozarth
(Address): Jacques Spur Idaho

15. Filed 12 8 1930. J. M. Lyle. By N. B. J. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h~~im~~ alive on Oct 9, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
no Doctor attended him at time of death. He was suffering [illegible] Hypertension Arterio sclerosis – Chr. Nephritis
(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) 2 yrs. 2 mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Lab & Physical ex

(Signed) Ralph M. Galey, M. D.
Nov 5, 1930 (Address) Lewiston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston Ida — Date of Burial: 12/11/1930
20. Undertaker: Casson Mortuary — Address: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 1 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72836

Registration District No. 15
Primary Registration District No.
Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

176

PLACE OF DEATH

County of Valley
City of Cabarton

2. FULL NAME Verna Jeane Griner

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	9	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Cascade Idaho

PARENTS

10. NAME OF FATHER James Griner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Garfield Wash
12. MAIDEN NAME OF MOTHER Cora Olmstead
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Clintonville Wis

14. Informant Mrs Cora Griner
(Address)

15. Filed Nov 29, 1930 Mrs. H. C. Gorton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Burned by accidental burning of residence
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W D Robb Coroner, M. D.
, 19 (Address) Valley County

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Alpha	Nov 28 1930
20. Undertaker W D Robb	Address Cascade Ida

RECEIVED DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72837

PLACE OF DEATH
County of Valley
City of Cascade Idaho

Registration District No. 15
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Earl Rufus Hendricks
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 27 - 1909

7. AGE: Twenty One Years; Months: May; Days: ; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Timber Worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Salt Lake Utah

PARENTS
10. NAME OF FATHER: Chester Arthur Hendricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Tusk Nevada
12. MAIDEN NAME OF MOTHER: Leonora Parks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ark

14. Informant: Chester A. Hendricks
(Address)

15. Filed Nov 29, 1930 Mrs. H. P. Gorton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1930, to Nov. 21, 1930
that I last saw him alive on Nov 20, 1930
and that death occurred, on the date stated above, at 4:00 a m.
The CAUSE OF DEATH* was as follows:
Ileo - colitis
(duration) 0 yrs. 0 mos. 4 ds.
CONTRIBUTORY (Secondary): German measles
(duration) 0 yrs. 0 mos. 10 ds.

18. Where was disease contracted if not at place of death? Cascade Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Roscoe C. Ward M. D.
10/21, 1930 (Address) Cascade Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: Cascade Idaho
Date of Burial: Nov 23 1930

20. Undertaker: A. D. Robb
Address: Cascade

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72838

PLACE OF DEATH
County of Valley
City of McCall

Registration District No. 13
Primary Registration District No.
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

188 C

2. FULL NAME Charles A Crusa

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mae Crusa

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54 29			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sawmill
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Carl Brown

9. BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10. NAME OF FATHER Jasper Newton Crusa
11. BIRTHPLACE OF FATHER (city or town) (State or Country) —
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Hazel Redmaker
(Address) Cabarton Idaho.

15. Filed Nov 29, 1930 Mrs. H. P. Yorton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 1926 to Oct 10, 1930
that I last saw him alive on Oct 8, 1930
and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:
Car, accident on Warren Hill
Body Crushed.
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? V none
Did an operation precede death? No Date of V
Was there an autopsy? No
What test confirmed diagnosis? none it.

(Signed) Dr W S Craft M. D.
Oct 10, 1930 (Address) McCall.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
McCall Idaho	Oct-14 1930
20. Undertaker A D Robb	Address Cascade Idaho

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72839

PLACE OF DEATH
County of Valley
City of Cascade

Registration District No. 15
Primary Registration District No.

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

160

2. FULL NAME Helen Marie Root

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~Single, Married, Widowed, or Divorced~~ (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	Oct	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Cascade Idaho

PARENTS

10. NAME OF FATHER Earl Curtis Root
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Dakota
12. MAIDEN NAME OF MOTHER Pearl Marris Downey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. [redacted] C. C. Root
Norwood Idaho
Nov 29, 1930 Mrs. N. C. Gorton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11, 1930, to Oct 17, 1930
that I last saw her alive on Oct 17, 1930
and that death occurred, on the date stated above, at 8 30 P m.
The CAUSE OF DEATH* was as follows:
Acterus Neonatorum

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Forest C Ward, M.D.
10-17, 1930 (Address) Cascade Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cascade Idaho	Oct. 17 1930
20. Undertaker	Address
A D Robb	Cascade Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25-M-1-19

RECEIVED DEC 11 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12810

Registered No. 17

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 89

Primary Registration District No. 2160

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. Melvin Owen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	Single

6. DATE OF BIRTH: Aug – 21 – 1929 (Month) (Day) (Year)

7. AGE: 1 Yrs. 1 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Downey, Idaho.

10. NAME OF FATHER J. Chester Owen

11. BIRTHPLACE OF FATHER (State or Country) Kaysville, Utah.

12. MAIDEN NAME OF MOTHER Louine Whitaker

13. BIRTHPLACE OF MOTHER (State or Country) Downey Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. Chester Owen
(Address) Downey Idaho.

15. Filed Dec. 9 – 1930 Mary A. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct – 7 – 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1930, to Oct – 7 – 1930 that I last saw him alive on Oct 6 – 1930, and that death occurred on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:
Hydrocephaloid

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Worthington M. D.
19..... (Address) Downey, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Downey, Idaho, Oct-9-1930 | DATE OF BURIAL

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-2[illegible] 1-10.

RECEIVED DEC 11 1930

DEC 11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No. 2160

(No. ..... St.)

File No. 12841

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phillip Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widdowed (Write the word.)

6. DATE OF BIRTH: June (Month) 2 (Day) 1842 (Year)

7. AGE: 88 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Pontypree Glamorganshire South Wales.

10. NAME OF FATHER: Phillip Phillips

11. BIRTHPLACE OF FATHER (State or Country): South Wales

12. MAIDEN NAME OF MOTHER: Mary Richards

13. BIRTHPLACE OF MOTHER (State or Country): South Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. J. Phillips

(Address) Downey, Idaho.

15. Filed Dec 9 1930 Mary C. Coffin Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH: Nov (Month) -13- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on Oct - 31 - 1930,

and that death occurred on the date stated above, at 2:20 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributor (Secondary) Chronic Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Hartvigsen M. D.

11-13-1930 (Address) Downey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. Guy Benson, D. P. Hadens

ADDRESS: Malad Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

f

DO NOT WRITE IN THIS SPACE
State File No. 72842

PLACE OF DEATH
County of Blaine
City of Minidoka

CERTIFICATE OF DEATH
Registration District No. 19
Primary Registration District No. 2015
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 69

2. FULL NAME Martin Earl Weaver

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

86 (B)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 25 1925

7 AGE Years 5 Months 9 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10 NAME OF FATHER Jacob M Weaver
11 BIRTHPLACE OF FATHER (city or town) (State or country) Kansas
12 MAIDEN NAME OF MOTHER Bessie Rumbock
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kansas

14 Informant Jacob M. Weaver
(Address) Minidoka Idaho

15 Filed Nov. 6, 1930 E W Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan (Month) 24 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 24, 1930, that I last saw him alive on Jan 24, 1930, and that death occurred, on the date stated above, at 5-40 p m.

The CAUSE OF DEATH* was as follows:
Ac. Sup. Mastoiditis. Left
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Sinus Thrombosis, Lat
sinus (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Jan 13-30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Leland Frazier, M. D.
, 19 (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Rupert Cemetry
Date of Burial Jan 1930

20. Undertaker W. G. Goodman
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

E

DO NOT WRITE IN THIS SPACE

State File No. 72343

PLACE OF DEATH

County of Minidoka

City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

Local Registrar's No. 49

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

182

2. FULL NAME James David Stewart

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Oct 23 1928

7 AGE: Years 2 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10 NAME OF FATHER LaVearl Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Utah

12 MAIDEN NAME OF MOTHER Martha Stowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Leverl Stewart

(Address) Rupert Idaho

15 Filed 11-26, 1930 E. H. Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July (Month) 15 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. A. Goodman M. D.

11-26, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetry

Date of Burial: 19

20. Undertaker

Address

FORM V. S. No. 5-25 M. 1-19.

DEC 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Jerome

City of Hazleton

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

State File No. 72844

Local Registrar's No. 50

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William S. Smyth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Nov (Month) 8 (Day) 1881 (Year)

7. AGE: 49 Yrs. 0 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Canada

10. NAME OF Father: William W Smyth

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Rebeca Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gertrude Smyth
(Address) Hazleton

15.
Filed Nov 26 1930 E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

129

16. DATE OF DEATH: Nov (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1930, to Nov 25 1930, that I last saw him alive on Nov 25 1930, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) 1 yrs. 2 mos. ..... ds.

Contributory (Secondary) Essential Hypertension

(Duration) 1 yrs. 2 mos. ..... ds.

(Signed) Hugh E. Dean M. D.

19 (Address) Burley Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: Nov 28 1930

20. UNDERTAKER: W. J. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

E

DO NOT WRITE IN THIS SPACE
State File No. 72845

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 51

2. FULL NAME Elmore Dewald

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) April 15-1929

7 AGE: Years 1, Months 2, Days 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10 NAME OF FATHER: John Dewald
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: Margaretta Hiel
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: John Dewald
(Address) Rupert Idaho

15 Filed 12-2, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 25 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1930, to June 25, 1930, that I last saw him alive on June 25, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Summer diarrhoea

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) Fayres H. Kinsey M. D.
11-7 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetry — Date of Burial: June 26 1930

20. Undertaker: W. J. Goodman — Address: Rupert Idaho

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72846

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 2015
Primary Registration District No. 19
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. ~~31~~ 52

90

2. FULL NAME Rada M Steele

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: April 5 1880

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 50 | Months 1 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10 NAME OF FATHER: Joseph Petterman
11 BIRTHPLACE OF FATHER (city or town) (State or country): Missouri
12 MAIDEN NAME OF MOTHER: Sarah Houck
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Missouri

14 Informant: Burton Steele
(Address) Rupert Idaho

15 Filed 12-2, 1930 E A Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: May (Month) 23 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to May 23, 1930, that I last saw her alive on May 23, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Chronic valvular disease of the Heart
..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J B Kenagy, M. D.
Nov. 6, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Pendleton Oregon | Date of Burial: May 28 1930
20. Undertaker: W. A. Gushman | Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 1 1930

STATE OF IDAHO J.B.K.
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72847

PLACE OF DEATH

County of Minidoka

City of Heyburn

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

Local Registrar's No. 53

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

112

2. FULL NAME Pomposa Mejia De Marin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Mexican

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sept 19 1881

6 DATE OF BIRTH (month, day and year)

7 AGE Years 49 Months 0 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10 NAME OF FATHER Benito Mejia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mexico

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mexico

14 Informant Jas Arias Marin

(Address) Heyburn Idaho

15 Filed 12-2, 1930 Ett Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Found dead lying on floor

Diagnosed acute indigestion

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J B Kenagy, M. D.

Nov. 6, 1930 (Address) Rockert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Rupert Cemetery

Date of Burial 22 Sept 1930

20 Undertaker W. A. Godman

Address Rupert Idaho

RECEIVED DEC 1 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72848

Registration District No. 19
Primary Registration District No. 2665
(No.)
Local Registrar's No. 54

PLACE OF DEATH
County of Minidoka
City of Rupert

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George C. Tiffany

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND *of*
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Glen Tiffany
(Address) Rupert Idaho

15 Filed 12-2, 1930 Ed Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1930, to Sept. 21, 1930, that I last saw h~~im~~ alive on Sept 20, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Apoplexy cerebral

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J B Kenagy, M. D.
Nov. 6, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	Sept 23 1930
20. Undertaker	Address
W. G. Goodman	Rupert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72849

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

(No. .....)

Local Registrar's No. 55

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

205-a

2. FULL NAME Marylyn H York

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) July 30 1930

7 AGE Years | Months 1 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10 NAME OF FATHER Cleveland York

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Cleveland York

(Address) Rupert Idaho

15 Filed 12-2, 1930 E H Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 11 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Accidental suffocation

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J B Kennedy, M. D.

Nov. 6, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery | Date of Burial: Sept 12 1930

20. Undertaker: Emmett Goodman | Address: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72850

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 56

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Myrtle Bean

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 19 1893

7 AGE: Years 37 | Months 8 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10 NAME OF FATHER: James M Fulmire
11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant: L. B. Bean
(Address): Rupert Idaho

15 Filed 12-2, 1930 Ed E Evans Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 22 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1930, to July 24, 1930, that I last saw her alive on July 21, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Chronic rheumatic Heart Disease
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J B Kenagy, M. D.
Nov 6, 1930 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Rupert Cemetery	July 24 1930
20. Undertaker	Address
W. A. Goodman	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72851

PLACE OF DEATH

County of Minidoka
City of Rupert

CERTIFICATE OF DEATH

Registration District No. 19
Primary Registration District No. 2015
(No. .....)

Local Registrar's No. 57

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Ella S Dowd

49

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Sept 11 1871

7 AGE: Years 59 | Months 0 | Days 5 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Missouri

PARENTS
10 NAME OF FATHER: T. J. Gilkerson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Indiana
12 MAIDEN NAME OF MOTHER: Ruth A Remington
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant: John Gilkerson
(Address) Garden City Mo

15 Filed 12-2, 1930 Elt Chuse
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 16 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1930, to Sept 16, 1930
that I last saw her alive on Sept 16, 1930,
and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the head of the pancreas
..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of Sept 11
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Fayre H. Kenagy, M. D.
11-6 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemet
Date of Burial: Sept 21 1930

20. Undertaker: W. A. Goodman
Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

K

DO NOT WRITE IN THIS SPACE

State File No. 72852

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Minidoka

City of Paul

Registration District No. 19

Primary Registration District No. 2012

(No. .....)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 58

2. FULL NAME Calvin Dee Lord

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

188C

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 28 1919

7 AGE: Years 10 | Months 11 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Nevada

PARENTS

10 NAME OF FATHER: Harry Lord

11 BIRTHPLACE OF FATHER (city or town) (State or country): Colorado

12 MAIDEN NAME OF MOTHER: Luella Otteson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: Mrs Luella Ottenson

(Address) Paul Idaho

15 Filed 12-2, 1930 Ett Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1930, to June 20, 1930, that I last saw him alive on June 20, 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Septicemia following automobile accident

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Paul Idaho

Did an operation precede death? Yes Date of June 20

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Sagie H. Kenagy, M. D.

11-5 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Heyburn Cemetery

Date of Burial: June 24 1930

20 Undertaker: W. A. Goodman

Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

K

DO NOT WRITE IN THIS SPACE

State File No. 72853

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Minidoka

City of Rupert

Registration District No. 19

Primary Registration District No. 2015

(No.) (If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Wesley D. Wall

113

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: 0 Years | Months 2 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rupert Idaho

PARENTS

10 NAME OF FATHER: Jake Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Nebraska

12 MAIDEN NAME OF MOTHER: Martha Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Illinois

14 Informant: Jake Wall
(Address): Rupert Idaho

15 Filed 12-2, 1930 E W Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 29 (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct 29, 1930, that I last saw him alive on Oct 24, 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:
Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Fayre H. Knapp, M. D.

11-6, 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery

Date of Burial: Oct 30 1930

20. Undertaker: W. A. Goodman

Address: Rupert Idaho

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

F.H.K.

DO NOT WRITE IN THIS SPACE
State File No. 12853

Registration District No. 19
Primary Registration District No. 2015
Local Registrar's No. 60

PLACE OF DEATH
County of Minidoka
City of Rupert
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ramona M Taylor

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

100a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 13 1929

7. AGE	Years	Months	Days	If LESS than 1 day,
	1			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Delta
(State or country) Utah

PARENTS

10. NAME OF FATHER Glenn Taylor
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Arizona
12. MAIDEN NAME OF MOTHER Leona E Cambell
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country) Utah

14. Informant Sarah L. Cambell
(Address) Rupert Idaho

15. Filed 6-10, 1930. Ett Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25, 1930, to Mar 27, 1930
that I last saw her alive on Mar 27, 1930
and that death occurred, on the date stated above, at 8 P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Fayne H. Kenyon, M. D.
Nov 6 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rupert Idaho	Mar 29 1930
20. Undertaker W. G. Goodman	Address Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72855

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 61

56

2. FULL NAME Alvin E. Lampe

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dec 15 1928

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 1 | Months 8 | Days 22 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Marysville Idaho

PARENTS
10 NAME OF FATHER: John H Lampe
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Emma Krager
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nebraska

14 Informant: John Lampe
(Address): Rupert Idaho

15 Filed 12-2, 1930 E W Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 8 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1930, to Sept 8, 1930, that I last saw him alive on Sept 8, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:
~~Rickets~~
Empyema
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Rickets
..... (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Sept 8 Date of yes
Was there an autopsy? no
What test confirmed diagnosis? X Ray
(Signed) Fayre H. Kenagy, M. D.
11-6, 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery
Date of Burial: Sept 10 1930

20. Undertaker: W. A. Goodman
Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Frac

DO NOT WRITE IN THIS SPACE
State File No. 72857

PLACE OF DEATH
County of Minidoka
City of Paul

CERTIFICATE OF DEATH
Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. 63

117

2. FULL NAME Alonzo P. Hume

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 13 1864

7 AGE: Years 66 | Months 7 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Iowa

PARENTS
10 NAME OF FATHER: William Hume
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER: ~~Dent~~ Jane Goodall
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iowa

14 Informant: Mrs Maud Hume
(Address) Paul Idaho

15 Filed Nov 6, 1930 Ett Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Jan (Month) ~~..~~ 8 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 8, 1930, that I last saw him alive on Jan 8, 1930, and that death occurred, on the date stated above, at 6 40 a. m.

The CAUSE OF DEATH* was as follows:
Appendicitis acute suppuration

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of Jan 4-30
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Paul Cemetery
Date of Burial: Jan 11 1930

20. Undertaker: W. G. Goodman
Address: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72859

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

2. FULL NAME Carl Freiberger

119

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18 — 1928

7. AGE

Years	Months	Days	If LESS than 1 day,
1	10	6	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho
(State or country)

PARENTS

10. NAME OF FATHER Frank Freiberger
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth Rousch
13. BIRTHPLACE OF MOTHER (city or town) Missouri
(State or Country)

14. Informant Frank Freiberger
(Address) Rupert Idaho

15. Filed Nov. 6, 1930 E H Elmore
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 24, 1930, to Apr 24, 1930
that I last saw him alive on Apr 24, 1930
and that death occurred, on the date stated above, at 11 30 a. m.
The CAUSE OF DEATH* was as follows:
Persistent peritonitis, General
(Cause — Influenzal infection
extended from Lungs.
..... (duration) ..... yrs. about mos. 3 ds.
CONTRIBUTORY (Secondary) Paralysis of intestine
..... (duration) ..... yrs. ..... mos. 2 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? yes Date of Apr 24-30
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Fagan, M. D.
....., 19..... (Address) Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Cemetery
Date of Burial Apr 28 1930

20. Undertaker W. A. Goodman
Address Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

DEC 11 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 72861

Local Registrar's No. 67

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clifford N. Hoopes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

6. DATE OF BIRTH: Oct. (Month) 10 (Day) 1928 (Year)

7. AGE: 2 Yrs. 5 Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Harrow Hoopes

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Nettie Austin

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harrow Hoopes
(Address) Rupert Idaho

15. Filed Nov. 6 1930 Elb Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

124

16. DATE OF DEATH: October (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1st 1930 to Oct. 10th 1930, that I last saw him alive on Oct. 9th 1930, and that death occurred on the date stated above, at 4:30 A M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. 11 ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kinnaugh M. D.

Oct 10 30 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cleveland Idaho	Dec 12 1930

20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert Idaho

RECEIVED DEC 11 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72862

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2015
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

111 B

2. FULL NAME Alvias H. Sullivan

(a) Residence. No. Rupert Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Mal
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of June 1 1873

6. DATE OF BIRTH (month, day and year)

7. AGE Years 56 Months 7 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter Guild
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS
10. NAME OF FATHER John Sullivan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Mary Parson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Artemicia Sullivan
(Address) 1258 Woods ave L. 9.

15. Filed Nov. 6, 1930 E W Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Feb 14, 1930
that I last saw him alive on Feb 14, 1930
and that death occurred, on the date stated above, at 8 59 a m.
The CAUSE OF DEATH* was as follows:
Ulcer of Duodenum (old)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
about
..... (duration) 6 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death 6 yrs ago Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Leland Frazier, M. D.
....., 19.... (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rupert Cemetery — Date of Burial Feb 16 1930

20. Undertaker W. A. Goodman — Address Rupert Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 1 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72863

PLACE OF DEATH
County of Minidoka
City of Paul

Registration District No. 19
Primary Registration District No. 2015
(No. .....)

Local Registrar's No. 70

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

114

2. FULL NAME Francis A. Ford

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 30 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer's wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10 NAME OF FATHER William Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Fanny A Osborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Blanch Hardman
(Address) Paul Idaho

15 Filed Nov 6, 1930 Ella Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH ~~Aug~~ Sept 4 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Sept 4, 1930, that I last saw her alive on Sept 4, 1930, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:
Infectious enteritis
(duration) ... yrs. ... mos. 3 ds.
CONTRIBUTORY (Secondary) Heart failure and hypostatic pneumonia
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical Signs
(Signed) Layne N. Kenagy, M. D.
Sept 7, 1930 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial 19
Burley Idaho	
20. Undertaker W. G. Goodman	Address Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72864

RECEIVED DEC 1 1930

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No. .....)
Local Registrar's No. 71

2. FULL NAME Barbara L Clark (If death occurred in a hospital or institution, give its name instead instead of street and number.) 100a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 29 - 30

7 AGE — Years: | Months: 1 | Days: | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rupert Idaho

PARENTS
10 NAME OF FATHER: Henry F Clark
11 BIRTHPLACE OF FATHER (city or town) (State or country): Montana
12 MAIDEN NAME OF MOTHER: Thelma Pruhsm
13 BIRTHPLACE OF MOTHER (city or town) (State or country): California

14 Informant: Henry F Clark
(Address): Paul Idaho

15 Filed 11-6, 1930 — E W Elmore, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 29 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Sept 29, 1930, that I last saw her alive on Sept 28, 1930, and that death occurred, on the date stated above, at 3 40 A. m.

The CAUSE OF DEATH* was as follows:
Influenza - Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) E W Elmore M. D.
11-6, 1930 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Paul Cemetery — Date of Burial: Oct 1 1930
20. Undertaker: W. F. Goodman — Address: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72866

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049

Local Registrar's No. 41

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

193

2. FULL NAME John Carlisle

(a) Residence. No. ..... St Maries Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 22 - 1887

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	7	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Penn

PARENTS

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Ireland

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or Country) Ireland

14. Informant Mrs John Carlisle
(Address) St Maries

15. Filed ....., 19..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h.. alive on ....., 19.....
and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:
Accidental gun-shot wound thru head

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) B Hope Coroner M. D.
Nov 17, 1930 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	Nov 20 1930

20. Undertaker	Address
Geo E Mitchell	St Maries

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 12 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of St Maries

Registration District No.

Primary Registration District No.

(No. St.)

File No. 72867

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Allen Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1930 (Year)

7. AGE ....Yrs....Mos. 4 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Milton W. Carter

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Elizabeth E. Dundee

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M W Carter

(Address) St Maries

15.

Filed ..... 191....

Local Registrar

MEDICAL CERTIFICATE OF DEATH 160

16. DATE OF DEATH Nov (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1930, to Nov 18 1930, that I last saw him alive on Nov 14 1930, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum. Gravis

(Duration) ....Yrs. ....mos. 4 ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) D E Cornwall M. D.

11/18 1930 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries

DATE OF BURIAL: Nov 15 1930

20. UNDERTAKER: Geo E Mitchell

ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72868

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 157

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eva Vinia Brooks

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of R. C. Brooks

6. DATE OF BIRTH (month, day and year) 4-6

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs. R. C. Brooks
(Address) Coeur d'Alene Ida

15. Filed Nov 30, 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
11-24, 1930, to 11-27, 1930
that I last saw her alive on 11-27, 1930
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Harold J. Sturges, M. D.
12-2-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Evergreen Park. Spokane Wash.	12-4 1930
20. Undertaker	Address
Cassedy Funeral Home	C d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 1 [illegible]

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72869

Local Registrar's No. 158

48 B

2. FULL NAME Frank Schinnerling

(a) Residence. No. 1108 "B" St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Hulda Schinnerling

6. DATE OF BIRTH (month, day and year) February 6 - 1860

7. AGE Years 70 Months 9 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired - Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Miner

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Charlie Schinnerling

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14. Informant Hulda Schinnerling
(Address) Coeur d'Alene, Ida

15. Filed Nov 29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 24, 1930

that I last saw him alive on Nov. 24, 1930

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

..... (duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? 1108 B St.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Harold J. Sturges M. D.

Nov. 28, 1930 (Address) CDA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cem. CDAlene — Date of Burial 12-1 1930

20. Undertaker Cassedy Funeral Home — Address CDAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

DEC 12 1930

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 30
Primary Registration District No. 1050
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72870

Local Registrar's No. 159

740

2. FULL NAME Emma Catherine Ward

(a) Residence. No. 407 - S. 12th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Michael Ward.

6. DATE OF BIRTH (month, day and year) 18-77-7-11

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	4	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fort Snelling Minn

PARENTS

10. NAME OF FATHER Patrick Henry
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Margaret Callahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Illinois

14. Informant M. A. Ward
(Address) C. D. A.

15. Filed Nov 24, 1930 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Nov 13, 1930
that I last saw h[er] alive on Nov 13, 1930
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. C. Myers, M. D.
11/14, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem. C'dAlene	11-15 1930

20. Undertaker Cossed Funeral Home
Address C'dAlene.

RECEIVED DEC 12 1930

PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

DO NOT WRITE IN THIS SPACE
State File No. 72871

Local Registrar's No. 160

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Grace Hoyt Tignor

(a) Residence. No. 606 Indiana St.
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

90

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C. H. Tignor

6. DATE OF BIRTH (month, day and year) Dec. 12-1877

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	11	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peoria Illinois

PARENTS

10. NAME OF FATHER Matt. Hoyt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Elizabeth - - -

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant T. J. Sparkman
(Address) Wallace Idaho

15. Filed Nov 29, 1930 W. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) - 23 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-28, 1930, to 11-23-, 1930
that I last saw her alive on 11-23-, 1930
and that death occurred, on the date stated above, at 4 10 p.m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) E. H. Teed M. D.
11-24-, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery - C d'Alene	11-25 1930
20. Undertaker	Address
Cassedy Funeral Home	C d'Alene

Every item of information should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72873

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 162

74a

2. FULL NAME Paul Anderson
(a) Residence. No. ..... St. Creston. Wash.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 1874 - 5 2
7. AGE Years 56 Months 6 Days 16 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Section worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer N. P. R. R.
9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER Andrew Nelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Rachel Ragnild
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lon Gudransdalen Norway

14. Informant Nels Anderson
(Address) Creston Wash.

15. Filed Nov 29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 18 (Month) (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Nov. 18, 1930
that I last saw him alive on Oct 23 1930
and that death occurred, on the date stated above, at 5 30 P m.
The CAUSE OF DEATH* was as follows: Apoplexy
(duration) Not known ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J C Dwyer, M. D.
Nov 20, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Creston Cem Creston Wash. Date of Burial 11-22-1930
20. Undertaker Cassedy Funeral Home Address Coeur d'Alene Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72874

PLACE OF ~~DEATH~~
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 164
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Herbert C. Strong.

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Clara Strong

6. DATE OF BIRTH (month, day and year) 1882 - 11 - 13

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neb.

PARENTS

10. NAME OF FATHER Don't Know.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Clara Strong
(Address)

15. Filed Nov 29 1930 N. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 15th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 15, 1930
that I last saw h[illegible] alive on Nov 15, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows: Accidental - Automobile
Skull Fracture

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Highway
Did an operation precede death? yes Date of Nov 14th
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) E. L. Brown M. D.
Nov 19, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Thomas Cem CDA.	11-19 1930
20. Undertaker	Address
Cassedy Funeral Home	CDAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72875

County of Kootenai
City of Coeur d'Alene
Registration District No. 3
Primary Registration District No. 1050
Local Registrar's No. 165

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James McDermott.

(a) Residence. No. 1306 - Pennsylvania St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Anna McDermott.

6. DATE OF BIRTH (month, day and year) 1845-11-16

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	84	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Shawnican Co. Canada

PARENTS

10. NAME OF FATHER Jas. McDermott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Nancy Wauhub.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Laura Blanchard
(Address) Wenatchee - Wash

15. Filed Nov 29, 1930 N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 16 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19__, to Nov 16, 1930
that I last saw him alive on Nov. 15, 1930
and that death occurred, on the date stated above, at 5 a. m.
The CAUSE OF DEATH* was as follows: -
Arteriosclerosis
Many vessels almost entirely occluded
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at his home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) E. L. Dr. Lin M.D.
Nov 19, 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. C D Alene	11-18 1930
20. Undertaker	Address
Cassedy Funeral Home	C D Alene.

RECEIVED DEC 1 2 1930

PLACE OF DEATH

County of Kootenai

City of Gebbs. Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72876

Local Registrar's No. 166

44 D

2. FULL NAME Peter Legacy

(a) Residence. No. ..... St. .....
(Usual place of abode)

Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Joseph Lime Legacy

6. DATE OF BIRTH (month, day and year) 1843 06 - 16

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	5	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) New Brunswick

PARENTS

10. NAME OF FATHER John Legacy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Batters. N. B.

12. MAIDEN NAME OF MOTHER Margaret La Veine

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Batters. N. B

14. Informant Mrs. Tom Legacy

(Address) Spokane Wash.

15. Filed Nov 29 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December, 1929, to Nov. 6, 1930, that I last saw him alive on Nov. 6, 1930 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial degeneration

..... (duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) John Conrad M. D.

Nov. 19. 1930 (Address) Coeur d'Alene. Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Thomas Cem. C D Alene	19

20. Undertaker	Address
Cassedy Funeral Home	C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72877

PLACE OF DEATH

County of Kootenai

City of Coeur D' Alene

Registration District No. 30

Primary Registration District No. 1050

Local Registrar's No. 167

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Edwin M. Nogle

(a) Residence. No. 415 Foster Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): April 19, 1854

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	7	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10. NAME OF FATHER: Fredrick Nogle

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn,

12. MAIDEN NAME OF MOTHER: Diadema Edwards

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant: Archie Nogle
(Address) Coeur D' Alene, Idaho.

15. Filed Dec 10, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2, 1930, to Dec 4, 1930 that I last saw him alive on Dec 4, 1930 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (apoplexy)

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary): Nephritis Chronic

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) F. J. McCaulay M. D.

Dec 7, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Post Falls, Idaho.

Date of Burial: 12/7/30 19

20. Undertaker: Mooney Mortuary Coeur

Address: D' Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC [illegible]

PLACE OF DEATH

County of Kootenai

City of Coeur d Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 20

Primary Registration District No. 1050

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72878

Local Registrar's No. 163

2. FULL NAME [redacted] Mann

(a) Residence. No. [redacted] St. 169

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 40			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) [redacted]

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Coroners Office

(Address) Coeur d Alene Idaho

15. Filed Nov 29, 1930 W. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Body found floating in Coeur d'Alene Lake
(probly Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Mooney Coroner, M. D.

11/13, 1930 (Address) Coeur d Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rathdrum, Ida.	Nov 16 1930
20. Undertaker	**Address**
Cassedy Funeral Home	C. D. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 1 9 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72879

Registration District No. 30
Primary Registration District No. 7050
Local Registrar's No. 168

PLACE OF DEATH
County of Kootenai
City of Rathdrum
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

41

2. FULL NAME Johanna Kiefer
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Phillip Kiefer Dec.

6. DATE OF BIRTH (month, day and year) aug 9th 1863

7. AGE	Years	Months	Days	If LESS than 1 day,
	67	2	30	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Germany Albirshausen

PARENTS

10. NAME OF FATHER Baeder.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER .....
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) .....

14. Informant Ernest Kiefer
(Address) Spirit Lake Idaho

15. Filed Nov 29, 1930 N. J. Sturgis Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-30-, 1930, to Oct-31-, 1930
that I last saw h..... alive on Oct-30-, 1930
and that death occurred, on the date stated above, at 12.30 a m.
The CAUSE OF DEATH* was as follows:
Acute idiopathic Peritonitis
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) Frank Henry, M. D.
10/31, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pine Grove Cemetery Rathdrum	11-2 1930
20. Undertaker	Address
Cassidy Funeral Home	Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 12 1930

PLACE OF DEATH

County of Kootenai

City of

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1050

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 72880

Local Registrar's No. 169

74a

2. FULL NAME Katherine Koth

(a) Residence. No. Hayden Lake St.
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 3, 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	7	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER John Schwaabe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) not known

14. Informant Jacob P. Cramp
(Address) Hayden Lake, Idaho.

15. Filed Dec 10, 1930 W. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 6, 1930 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930, to Dec. 6, 1930
that I last saw her alive on Dec. 3, 1930
and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
with paralysis

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) General Arterio Sclerosis and Old Age (duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Mears, M. D.

12/8, 1930 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cemetery	12/9/30 19

20. Undertaker	Address
Mooney Mortuary	Coeur D' Alene,

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72881

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

74A

2. **FULL NAME** Almira Marlenee Smith

(a) Residence. No. Salmon (Usual place of abode.) Idaho St. (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 4 yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female		married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert S. Smith

6. DATE OF BIRTH (month, day and year)

7. AGE	63 Years	1 Months	19 Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Morrisburg (State or country) Iowa

PARENTS

10. NAME OF FATHER Benjamin Marlenee

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Lucy Roberts

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant Mrs. C. Smith (Address) Salmon Ida.

15. Filed Dec. 10, 1930 Chas Bellamy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 7th (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1930, to Dec 7, 1930, that I last saw h.er alive on Dec 7, 1930 and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) J. S. Wright, M. D.
Dec 9, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal: Salmon Cemetery — Date of Burial: 12-10-1930

20. Undertaker W. C. Doeble — Address: Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72862

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Lemhi
City of Baker

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Rudolph Wetter

(a) Residence. No. Baker Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72 about			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) was supported by County
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) not known

PARENTS

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) not known

14. Informant (Address) Wm C Doebler Salmon, Idaho

15. Filed Dec 10, 1930 Chas Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH about Nov 16th (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at not known m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Chronic
Valvular heart disease,
.....(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm C Doebler Coroner M. D.
12/2, 1930 (Address) Salmon Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	12/3/1930

20. Undertaker Wm C Doebler Address Salmon Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 1 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72883

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Louisa Cathrine Davis Sanderson

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of W. G. Sanderson 1848

6. DATE OF BIRTH (month, day and year) Dec. 11. 1848

7. AGE 8[illegible] Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mercer Co. Missouri

PARENTS
10. NAME OF FATHER Joel Davis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentuckey

14. Informant (Address) Gerry Sanderson Salmon Idaho

15. Filed Dec 10, 1930 Chas Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1930, to Nov 25, 1930
that I last saw her alive on Nov. 25, 1930
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach

About (duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Senile debility
Several years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hamme, M. D.
Dec 4, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 12-28" 1930

20. Undertaker Wm C Doebler
Address Salmon Idaho

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72884

RECEIVED DEC 13

PLACE OF DEATH

County of Lemhi

City of Salmon

Registration District No. 41

Primary Registration District No. 2116 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

69

2. **FULL NAME** Harmeth Royal Smith

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16		23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Baker North Dakota

PARENTS

10. NAME OF FATHER Benjamin Thomas Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Stuart Iowa

12. MAIDEN NAME OF MOTHER Edith Rae Waller

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois

14. Informant (Address) Benjamin T. Smith Salmon Idaho

15. Filed Dec 10, 1930 Clio Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25, 1930, to Nov 29, 1930, that I last saw him alive on Nov 29, 1930, and that death occurred, on the date stated above, at 12:50 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) F. S. Wright, M. D.

12/1, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	12-1st 1930

20. Undertaker	Address
Geo C Doebler	Salmon Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72885

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virgil Monton Harris Jr. 113
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 5, 1930

7. AGE Years Months 3 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Salmon Idaho.
(State or country)

PARENTS
10. NAME OF FATHER Virgil Monton Harris
11. BIRTHPLACE OF FATHER (city or town) Dyke
(State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Frieda Mogg
13. BIRTHPLACE OF MOTHER (city or town) Stettin A.K.M.
(State or County) Germany.

14. Informant (Address) Mrs Virgil Harris Salmon Idaho.

15. Filed 12-10, 1930 Clro Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 5th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Nov 5, 1930
that I last saw him alive on Nov 5, 1930
and that death occurred, on the date stated above at 1-30 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Diarrhoea and enteritis
(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) congenital debility
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
Dec 4, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial Nov-7" 1930

20. Undertaker Jim C Doebler
Address Salmon Idaho

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72886

PLACE OF DEATH

County of [illegible]
City of Salmon

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Crankrite)
(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. FULL NAME Daisy Miller Crankrite
(a) Residence. No. Salmon Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX [illegible]
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Crankrite

6. DATE OF BIRTH (month, day and year) January 31st 1867

7. AGE Years 62 Months 9 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS
10. NAME OF FATHER Charles Miller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Mary Mitchell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ~~Ohio~~ Indiana

14. Informant (Address) George Crankrite Salmon Idaho

15. Filed ....., 19.....
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 4th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Nov. 4, 1930
that I last saw her alive on October 24, 1930
and that death occurred, on the date stated above, at 3-15 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus; arterial hypertension; two cerebral hemorrhages.

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) O. Stratton M. D.
Nov. 4, 1930 (Address) Salmon Ida

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 11-7th 1930

20. Undertaker Wm C. Doebler
Address Salmon Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72887

Local Registrar's No. 204

74a

PLACE OF DEATH

County of Jerome
City of Hazelton
Registration District No.
Primary Registration District No.
(No. 8 Mi E ½ N Hazelton Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joseph Butterworth

(a) Residence. No. Hazelton St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Butterworth

6. DATE OF BIRTH (month, day and year) Jan 10 1865

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm Work.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant J H Butterworth
(Address)

15. Filed Dec 8th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 25 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Nov 25, 1930, that I last saw him alive on Nov 25, 1930, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E Brown M. D.
Dec 2, 1930 (Address) Rupert

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	11-29 1930
20. Undertaker	Address
White Mortuary Inc	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

R DEC 19 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72888

Registration District No. 37
Primary Registration District No. 2081
Local Registrar's No. 203

PLACE OF DEATH
County of Twin Falls
City of Kimberly
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Martha A. Dunn

(a) Residence. No. Kimberly Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Crandal Dunn

6. DATE OF BIRTH (month, day and year): Oct 31 1857

7. AGE: Years 73 | Months 0 | Days 26 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Utah

PARENTS

10. NAME OF FATHER: Thomas W. Stewart
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Charlotte George
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wales

14. Informant: Mrs. L. F. Dunn
(Address) Kimberly Ida

15. Filed Dec. 5th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17th, 1930, to Nov 28th, 1930, that I last saw h[e] alive on Nov 27th, 1930, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:
Pneumonia (Broncho)
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. C. Lamb, M. D.
Dec 2d, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Nov 28th, 1930

20. Undertaker: F. E. Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

REC'D DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72889

PLACE OF DEATH

County of Twin Falls,

City of Twin Falls,

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No. 201

(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George D. Nelson

(a) Residence. No. Hazelton, Idado. R.F.D. #1 St.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred. 16 yrs. mos. ds. (Usual place of abode) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 14th 1911

7. AGE 19 Years | 10 Months | 13 Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kimberly Idaho.

PARENTS

10. NAME OF FATHER Lars P. Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Betty Nelson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Lars P. Nelson

(Address) Hazelton, Ida. R.F.D. #1

15. Filed Dec. 1, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 27th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1930, to Nov 27, 1930

that I last saw him alive on Nov 26, 1930

and that death occurred, on the date stated above, at 4.45AM m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) H W Wilson, M. D.

Nov 28, 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	Nov. 29th 1930

20. Undertaker	Address
Grossman Mortuary,	Twin Falls, Ida.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72890

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 207

PLACE OF DEATH
County Twin Falls
City of Twin Falls
(No.) 140
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agatha Weigrall
(a) Residence. No. Rock Creek St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 15 1884

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	1	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington

PARENTS
10. NAME OF FATHER John H Wells
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Rachael White
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo

14. Informant Frank W Weigrall
(Address) Hansen #2

15. Filed Dec 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 26 1930 5 pm
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11/26, 1930
that I last saw her alive on 11/26, 1930
and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage from dislocated placenta.
(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Accepto post presentation.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Version Date of 11/26/30
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
11/29, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rock Creek	Dec 5th 1930

20. Undertaker F E Drake Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72891

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 202

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

2. FULL NAME Amanda Turley
(a) Residence. No. Hospital St. Dr Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Oct 19/1861
7. AGE: 69 Years | Months: 1 | Days: 6 | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS
10. NAME OF FATHER: Chas - Childress
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky
12. MAIDEN NAME OF MOTHER: Sarrah Day
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

14. Informant: Leloh - Boehm
(Address) Husum Wash

15. Filed Dec 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 25 1930 (Month) (Day) (Year) 10-30
17. I HEREBY CERTIFY, That I attended deceased from ....., 19 ..... to on 11/25, 1930
that I last saw her alive on 11/25, 1930
and that death occurred, on the date stated above, at 10:30 A.m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) ..... yrs. ..... mos. 4 hrs
CONTRIBUTORY (Secondary): Arterio-sclerosis
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
11/29, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Nov 28th 1930
20. Undertaker: F. C. Drok | Address: F. Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72892

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
(No.) Twin Falls County Gen. Hospital
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 202

137

2. FULL NAME Hattie Mae Hansen

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wilford L. Hansen

6. DATE OF BIRTH (month, day and year) Aug 19 - 1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	3		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Thomas Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Emma Goodwin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs. Thos Campbell
(Address) 157 - N. Washington Twin Falls

15. Filed Nov. 29th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1930, to Nov. 24, 1930
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 3:00 a. m.
The CAUSE OF DEATH* was as follows:
Abdom. Tumor - Probably Cancer

(duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary) Pelvic tumor - Cystic Ovary
(duration) 8 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical examination
(Signed) John Morgan, M. D.
11/26 1930 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Cemetery	11-26 1930
20. Undertaker	**Address**
White Mortuary Inc	Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12893

PLACE OF DEATH

County of Twin Falls,
City of Twin Falls,
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 199

(No. At Home Addison Ave R.F.D.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

128

2. FULL NAME Lena B. Young,

(a) Residence. No. Addison Ave, R.F.D. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Otto Young

6. DATE OF BIRTH (month, day and year) June 19- 1874

7. AGE	55 Years	5 Months	2 Days	If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ill.
(State or country)

PARENTS

10. NAME OF FATHER John Hoover
11. BIRTHPLACE OF FATHER (city or town) Pa.
(State or Country)
12. MAIDEN NAME OF MOTHER Lena B. Hoover
13. BIRTHPLACE OF MOTHER (city or town) Ill.
(State or Country)

14. Informant Otto Young,
(Address) Twin Falls, Ida. Addison Ave. R.F.D.

15. Filed Nov 29th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 23, 1930, that I last saw h[illegible] alive on Nov 21, 1930, and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:
Acute Nephritis — Cause unknown.
(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary
(Signed) J. H. Wilson, M. D.
Nov 26, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Ida.	Nov. 26 1930

20. Undertaker Crossman Mortuary Address Twin Falls,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72894

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 198

(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Wakley Hospital
(a) Residence. No. Buhl St. Dr. Weaver
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept. 15/1930
7. AGE Years — Months 2 Days 7 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Dell Cavery
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Michigan
12. MAIDEN NAME OF MOTHER Mary Wakley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant Mary Wakley
(Address) Buhl

15. Filed Nov. 29th 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH 11—

16. DATE OF DEATH Nov. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-21, 1930, to 11-21, 1930
that I last saw her alive on 11-21, 1930
and that death occurred, on the date stated above, at 11 30 a m.
The CAUSE OF DEATH* was as follows:
Malnutrition
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) C. Russell Weaver, M. D.
11-21, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial Nov 20 1930
20. Undertaker F. E. Drake — Address Twin Falls

REC'D DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72895

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 196
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.) Dr. Lamb's

2. FULL NAME Mrs. Brackett Hospital
(a) Residence. No. Research St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Apr.
7. AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Colo
PARENTS
10. NAME OF FATHER: W. O. Brackett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Nebr
12. MAIDEN NAME OF MOTHER: Lucy Stone
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ill
14. Informant: J. F. Clark
(Address): Filer Idaho
15. Filed Dec. 29th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 17 (Month) (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 22d, 1930, to Nov 17th, 1930
that I last saw h[illegible] alive on Nov 17th, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
My[illegible] Conditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease (duration) yrs. mos. 5 ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb M. D.
11-20-, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Dec 9 1930
20. Undertaker: L. L. Drake — Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72896

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 197

(No. 101a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ben Covington Hospital Dr Weaver
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Apr. 1866

7. AGE 64 Years | Months 7 | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant F. E. Drake (Coroner)
(Address) Twin Falls

15. Filed Nov. 29th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1930, to Nov. 14, 1930
that I last saw him alive on Nov. 14, 1930
and that death occurred, on the date stated above, at 5:30 p.m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
..... (duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. D. Weaver, M. D.
11/22, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls | Date of Burial Nov 22 1930

20. Undertaker F. E. Drake | Address Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 13 1930

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72897

County of Twin Falls
City of Twin Falls
Registration District No.
Primary Registration District No.
Local Registrar's No. 25
(No. ,)
(If death occurred in a hospital or institution, give its name instead of street and number.)

21

2. FULL NAME Janett Locklear

(a) Residence. No. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 12. 1930.

7. AGE Years	Months	Days	If LESS than 1 day,
	10	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Belen NewMexico

PARENTS

10. NAME OF FATHER Oscar Locklear
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Bennie Foster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Oscar Locklear
(Address) Route # 2. Jerome Idaho.

15. Filed Nov. 28th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November, 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9, 1930, to Nov 14, 1930
that I last saw her alive on Nov 14, 1930
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. C. Langenwalter M. D.
Nov 15, 1930 (Address) Twin Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Idaho	Nov. 15. 30

20. Undertaker	Address
P. J. Grossman	Twin Falls Ida

Form V. S. No. 3 20M.1-16-32 RECEIVED DEC 13 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 72898
Registered No. 194

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Homer Giles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 16 (Day) 1911 (Year)

7. AGE: 19 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Farm work

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles A Giles

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Laverne Provost

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph F. Giles
(Address) Richfield Ida.

15.
Filed Nov 24 th 1930 Elizabeth J. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13- 1930, to Nov 13 1930, that I last saw him alive on Nov 13 - 1930, and that death occurred on the date stated above, at 12:25 M.

The CAUSE OF DEATH* was as follows:
Fractured skull
due to an accident
(Duration) ..... yrs. ..... mos. 45 Minutes ds.
Contributory (Secondary) Hit by a Railroad Engine in Crossing at Twin Falls
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) H N Leete M. D.
11-15 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Richfield Idaho

19. ~~PLACE OF BURIAL OR REMOVAL~~ Shoshone
DATE OF BURIAL ..... 191...

20. UNDERTAKER White Mortuary
ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 72899

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No. Twin Falls County Gen. Hospital

Local Registrar's No. 193

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME James Byron Williams

44

(a) Residence. No. Filer, Ida, Route #2 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Williams

6 DATE OF BIRTH (month, day and year): Jan 10 - 1877

7 AGE: Years 53 | Months 10 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Minnesota

PARENTS

10 NAME OF FATHER: Cebias Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Anna Pittijohn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Mrs. Mary Williams

(Address) Filer, Ida, Route #2.

15 Filed Nov. 24th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov. (Month) 13 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July, 1930, to Nov 13, 1930, that I last saw him alive on Nov 12, 1930, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary): Broncho Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 8-1930

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Operation

(Signed) A. A. Newberry M. D.

Nov 14, 1930 (Address) Filer Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Filer Cemetery

Date of Burial: 11-16 1930

20. Undertaker: White Mortuary, Inc

Address: Twin Falls Ida.

DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72900

PLACE OF DEATH
County of Twin Falls
City of Filer

Registration District No. 37
Primary Registration District No. 2086
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2363
192

2. FULL NAME Emma R. Bassford
(a) Residence. No. Filer St. Or Dwight 101a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 14/1851

7. AGE Years 79 Months 5 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ind.

PARENTS
10. NAME OF FATHER Samuel Overman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind
12. MAIDEN NAME OF MOTHER Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind.

14. Informant H. A. Bassford
(Address) Veteran Wyoming

15. Filed Nov. 24th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH 8-15

16. DATE OF DEATH Nov. (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1930, to Nov. 9, 1930
that I last saw her alive on Nov. 9, 1930
and that death occurred, on the date stated above, at 8:15 P.m.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) H. A. Dwight M. D.
Nov. 11, 1930 (Address) Filer

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Beloit, Kansas Date of Burial Nov. 1930

20. Undertaker F. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72901

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 191

(No. Twin Falls Lois, St 268)
(If death occurred in a hospital or institution, give its name instead of street and number.)

22

2. FULL NAME Mable E. Caudle

(a) Residence. No. House Creek. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 21St 1915

7. AGE 15 Years 8 Months 2 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Three Creek Ida.

PARENTS

10. NAME OF FATHER Joe Caudle

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Iva Curtis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Joe Caudle
(Address) House Creek

15. Filed Nov. 24th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1930, to Nov 7th, 1930 that I last saw her alive on Nov 7th, 1930 and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows:
Antero-Poliomyletic acute Epidemic (upper segments cord)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Paralysis Respiration

(duration) yrs. mos. ✓ ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [illegible], M. D.

11-7-30, 19 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Ida, Date of Burial: Nov, 8 1930

20. Undertaker: P.J. Grossman, Twin Falls, Ida Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72902

PLACE OF DEATH

County of
City of Shoshone

Registration District No. 37
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 190

48 B

2. FULL NAME Andrew Jackson Newman

(a) Residence. No. Shoshone Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Lela Newman.

6. DATE OF BIRTH (month, day and year) Sept. 2 - 1864.

7. AGE 66 Years 66 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Monticello Missouri.

PARENTS

10. NAME OF FATHER Henry Ed. Newman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia.
12. MAIDEN NAME OF MOTHER Margret Hamilton
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Marvin A. Newman
(Address) Twin Falls.

15. Filed Nov. 24th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 4 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1929, 19, to Nov 4, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 3.30 A m.
The CAUSE OF DEATH* was as follows:
Chronic Fibrous Myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Fibrinous Bronchitis (duration) (unknown)

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) T. E. Harrott, M. D.
11/4, 1930 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Nov 6 1930

20. Undertaker P. J. Grossman
Address

RECEIVED DEC 1 3 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72903

PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of Twin Falls Primary Registration District No. 2085 Local Registrar's No. 189

(No. Twin Falls County Hospital)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Glen W. Cozad

(a) Residence. No. Eden, Ida St.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Cozad

6 DATE OF BIRTH (month, day and year) June 8-1901

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
29	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ault Colo

PARENTS

10 NAME OF FATHER W. O. Cozad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary L. Whitacre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mo.

14 Informant Ray Cozad

(Address) Eden Ida

15 Filed Nov 5th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov (Month) 1 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1930, to Nov 1, 1930, that I last saw him alive on Nov 1, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Widal

(Signed) J. E. Langenwalter M. D.

Nov 3, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19c ~~Place of Burial, Cremation, or~~ Removal: Ault Colorado

Date of ~~Burial~~ removal 11-4 1930

20. Undertaker: White Mortuary

Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 13 1930

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 72904

Local Registrar's No. 188

100a

2. FULL NAME Frank C. Williams

(a) Residence. No. Murtaugh, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Minnie Morland Williams

6. DATE OF BIRTH (month, day and year) Aug. 18th -1884

7. AGE 46 Years 2 Months 12 Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washington,

PARENTS

10. NAME OF FATHER Charles Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Anna Twichell

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant Mrs. Minnie Williams
(Address) Murtaugh. Ida.

15. Filed Nov 5th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 1St. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/7/30, 19, to 11/1, 1930

that I last saw him alive on 11/1, 1930

and that death occurred, on the date stated above, at 6.50PM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Strept. Occi. & Pneumon. Infec. of Throat & Nasal

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? home

Did an operation precede death? Tonsilectomy Date of 10/15/30

Was there an autopsy? No

What test confirmed diagnosis? Phys. Findings & Chem Lab

(Signed) Dr John R Morgan, M. D

11/1, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Ida. Date of Burial Nov. 4TH 193

20. Undertaker P.J.Grossman, Twin Falls Idaho. Address

FORM V. S. No. 3-25 M. 1-19. RECEIVED DEC 15 1930

72905

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19 F

Primary Registration District No. 2015

(No. ..... St.)

State File No. 72905

Local Registrar's No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert H Nutting

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1860 (Year)

7. AGE: 70 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF Father: Francis M Nutting

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Lilee

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Serena Nutting
(Address) Rupert Idaho

15. Filed Dec. 13 1930 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: Nov (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1926, to Nov 12 1930, that I last saw him alive on Nov 11 1930, and that death occurred on the date stated above, at 12 15 A M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

About (Duration) 15 yrs. ..... mos. ..... ds.

Contributory (Secondary) Ascending paralysis

About (Duration) 5 yrs. ..... mos. ..... ds.

(Signed) Leland Frazier M. D.

12-15 1930 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery

DATE OF BURIAL: Nov 16 1930

20. UNDERTAKER: W. G. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 15 1930

72906

DO NOT WRITE IN THIS SPACE

State File No. 72906

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 7004

Local Registrar's No. 107

PLACE OF DEATH

County of Ada

City of Boise

(No. U.S.V.B., Boise, Idaho)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME TINDELL, Gerard S.

(a) Residence. No. ..... St. Cambridge, Idaho 90
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 22, 1896

7. AGE	Years	Months	Days	If LESS than 1 day,
	34	9	20	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) xx

(c) Name of employer xx

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER J. W. Tindell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) xx

12. MAIDEN NAME OF MOTHER xx

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) xx

14. Informant U.S.V.B., Boise, Idaho
L.H. Beaman
(Address)

15. Filed 12-13, 1930 W.K. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1927, 19..., to Dec. 12, 1930, that I last saw him alive on Dec. 12, 1930, and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Dilatation cardiac acute.

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myelitis, dorsal region; Nephritis chr. interstitial.

..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F. C. SMITH, Reg. Med. Off., M. D.

12-13-30, 19... (Address) U.S.V.R., Boise, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cambridge Ida	12-15 1930

20. Undertaker Schreiber & McCaun, Boise Ida. Address Cambridge, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12908

DO NOT WRITE IN THIS SPACE
State File No. 72908

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 302
(No. St. Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gregore Semechy (Semecky) 74a
(a) Residence. No. 509 North 5th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of has wife left here in the old Country and was married 1881

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about	49			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bulgaria

PARENTS

10. NAME OF FATHER Not obtainable
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bulgaria
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bulgaria

14. Informant Elia K. Georgeff (Address) Boise, Ida.

15. Filed 12-1, 1930 W. H. Roades Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24, 1930, to Nov 25, 1930, that I last saw him alive on Nov 24, 1930, and that death occurred, on the date stated above, at 11 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Skull fracture
4 days ago (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? By autopsy
(Signed) Fred A Pettingill M. D.
12/1, 1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: 12/2 1930
20. Undertaker: Schreiber & McCann — Address: Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 [illegible]

72909

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72909

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 64

2. FULL NAME Albert Schmidt

74a

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) No information

7. AGE Years 59 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER — — Schmidt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Mrs. Frank Schultz
(Address) ~~Kellogg, Idaho.~~

15. Filed Dec. 19, 1930 Mrs. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1930, to Dec. 11, 1930
that I last saw him alive on Dec. 11, 1930
and that death occurred, on the date stated above, at 3 p. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

..... (duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Respiratory center paralysis

..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? clinical.
(Signed) T. W. Laraway M. D.
12-12-, 1930 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Spokane, Wash | Date of Burial 11/14/30 19

20. Undertaker M. C. THornhill | Address Kellogg Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

72910

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72910

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 232
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Willard A. Dickinson
(a) Residence. No. Boise, Idaho. St. 101 a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ethel Dickinson

6. DATE OF BIRTH (month, day and year): January 6th 1896

7. AGE: 34 Years | Months: 11 | Days: 18 | If LESS than 1 day, ---- hrs. or ---- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Sheet Metal Worker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Janesville, Wis.

PARENTS

10. NAME OF FATHER: Ansel Dickinson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis.
12. MAIDEN NAME OF MOTHER: Jane Jamieson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Wis.

14. Informant (Address): Ansel Dickinson. Boise, Idaho.

15. Filed 12-26 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 24th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/20, 1930 to 12/24, 1930
that I last saw him alive on 12/24, 1930
and that death occurred, on the date stated above, at 8 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) 4th post operative day patient got out of bed to get some eggs. and reopened the (duration) yrs. mos. ds.
Broadmaster [illegible] chronic [illegible]
Did an operation precede death? Yes Date of 12/17 + 12/23
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Ralph Hall, M. D.
12/24/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/26/30
20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

72911

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7291

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004
(No. U.S.V.B., Boise, Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 114

128

2. FULL NAME DUNN, Leon M.

(a) Residence. No. ..... St. St. Maries, Idaho
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Elsie Dunn

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	43	8	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Forest Ranger
(b) General nature of industry, business, or establishment in which employed (or employer): xx
(c) Name of employer: xx

9. BIRTHPLACE (city or town) (State or country): Iowa

PARENTS

10. NAME OF FATHER: Robert Dunn
11. BIRTHPLACE OF FATHER (city or town) (State or Country): xx
12. MAIDEN NAME OF MOTHER: xx
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): xx

14. Informant: U.S.V.B., Boise, Idaho
(Address) V.Vogel

15. Filed 12-30, 1930 W. H. Rhodes
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 26, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1930, 19, to Dec. 26, 1930, that I last saw him alive on Dec. 26, 1930, 19 and that death occurred, on the date stated above, at 8:20 P.m.

The CAUSE OF DEATH* was as follows:
Pyleonephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Basal Meningitis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Cystoscopy & Autopsy
(Signed) F. C. SMITH, Reg.Med.Off., M. D.
12-27-30, 19 (Address) U.S.V.B.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane Wash
Date of ~~Burial~~ ship: 12-27 1930

20. Undertaker: Mrs Elsie Dunn
Consigned to Ernest
Address: St.Maries, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICAL should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

72912

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72912

PLACE OF DEATH
County of Boundary
City of Naples,
Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Archie Wallace Miller,

(a) Residence. No. St. 8 & B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Arrissia Miller

6. DATE OF BIRTH (month, day and year) Mar. 22, 1868

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Timber worker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) McKeon County Penn.

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant Mrs. Arrissia Miller,
(Address) Naples, Idaho.

15. Filed Sept. 4, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic myocardial degeneration.
(Found dead in bed)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas Bonnell M. D.
Sept 4th, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Sept. 4, 1930

20. Undertaker	Address
H.R. Crounh,	Bonners Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

72913

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72913

Registration District No. 5-2

Primary Registration District No. 2-36

Local Registrar's No.

PLACE OF DEATH

County of Bear Lake

City of Montpelier (No. 128)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Isaac Lennan.

(a) Residence. No. Montpelier Idaho St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 21 -

7. AGE	Years	Months	Days	If LESS than 1 day,
	53	8	9.	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Book-keeper (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Don Isaac Lennan

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Catherine Innes

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant Mrs J Lennan

(Address) Logan Gooding Idaho

15. Filed 1-3-31, 19 W H Kinney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1930, to Aug 30, 1930

that I last saw h[illegible] alive on Aug 30, 1930

and that death occurred, on the date stated above at 6:21 P m.

The CAUSE OF DEATH* was as follows:

Uremia Retention
Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) External & Internal Hemorrhoids (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-16-30

Was there an autopsy? no Date of 8-24-30

What test confirmed diagnosis?

(Signed) H. H. Galbraith M. D.

Aug 31, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montpelier Idaho	Sept 3 1930

20. Undertaker J A Williams Address Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

RECEIVED JAN 5 1931

72974

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72914

Registration District No. 129
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH
County of Nez Perce
City of Near Culdesac (No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Isaac Ward (Mrs Laura A. Ward) 29

(a) Residence. No. Near Culdesac Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓ Isaac Ward

6. DATE OF BIRTH (month, day and year) Aug 17-1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	62	3	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Benj Onley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.
12. MAIDEN NAME OF MOTHER Emely Sudds
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mass

14. Informant C L Ward
(Address) Culdesac

15. Filed Nov 30, 1930. George Gaigned M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31—, 1930, to Nov. 30—, 1930
that I last saw her alive on Nov. 18—, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaigned M. D.
, 19 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lewiston	
20. Undertaker	Address
Nassar Mortuary Inc	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 26 1930

72915

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72915

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 90
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

89

2. FULL NAME Oscar Crittenden
(a) Residence. No. ..... St. Ogden, Utah.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Cole Crittenden

6. DATE OF BIRTH (month, day and year) March 6th, 1868

7. AGE Years 62 Months 9 Days 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Passenger train
(c) Name of employer Utah Idaho Central R.R. Co.

9. BIRTHPLACE (city or town) (State or country) Hoytsville, Utah.

PARENTS
10. NAME OF FATHER Chauncey Crittenden,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.
12. MAIDEN NAME OF MOTHER Elizabeth Wareing,
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant Irwin Crittenden
(Address) Hoytsville, Utah.

15. Filed 12/12, 1930 A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-7, 1930, to 12-7, 1930
that I last saw him alive on 12-7 1930
and that death occurred, on the date stated above, at 6 33 a m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical
(Signed) A. R. Cutler M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ogden Ut. Date of Burial Dec. 10 1930

20. Undertaker M. W. Hendrick Address Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

72916

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72916

Registration District No. 1

Primary Registration District No. 2003

Local Registrar's No. 19

PLACE OF DEATH

County of Ada

City of Meridian (No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bartemus Palmer 74a

(a) Residence. No. St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 20, 1844

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	15	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer & Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Allen Co Ohio

PARENTS

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Logan Palmer

(Address) Kuna Ada Rt 2

15. Filed 12-6, 1930 T F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH The 5th (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1930, to Dec. 5, 1930

that I last saw he alive on Dec 5, 1930

and that death occurred, on the date stated above, at 6:35 m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. 30 Ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Personal

(Signed) T. F. Neal, M. D.

12-6-, 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Ada	12-7 1930

20. Undertaker B. W. Robinson Address Meridian Ida

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. Ada 72918

PLACE OF DEATH

County of Ada

City of Meridian Id

Registration District No. 1

Primary Registration District No. 2005

Local Registrar's No. 20

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George E Powell

(a) Residence. No. Meridian Id St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

8 & B

8 PM

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 16 - 1841

7. AGE	Years	Months	Days	If LESS than 1 day,
	89	6	ns	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion Co Ohio

PARENTS

10. NAME OF FATHER George Powell

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eingland (Appleton)

12. MAIDEN NAME OF MOTHER Hannah Snaile

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Appleton England

14. Informant Mrs Mary French

(Address) Meridian Idaho

15. Filed 12-16 1930 J F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J F Neal, M. D.

12 - 16 1930 (Address) Meridian

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	Dec 17. 1930
20. Undertaker	Address
W S Mater	Meridian Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 7 19[illegible]

PLACE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72914

County of Ada

City of Meridian

Registration District No. 11

Primary Registration District No. 2003

Local Registrar's No. 18

(No. V.C.B.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ellis Wolfe 24

(a) Residence. No. S Meridian St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meridian Id

PARENTS

10. NAME OF FATHER Noel P. Wolfe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan Ohio

12. MAIDEN NAME OF MOTHER Geraldine O'Mara

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Snohomish Washington

14. Informant Mrs. Noel P. Wolfe

(Address) Meridian Idaho R. 2

15. Filed 11-23, 1930 J F. Reed Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930 to Nov 22, 1930

that I last saw her alive on Nov. 22, 1930

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

30 hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) V. C. Bellman M. D.

Nov 24, 1930 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery	Nov 24 1930

20. Undertaker W. S. Hatter Address Meridian Id

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72920

PLACE OF DEATH
County of Ada
City of Meridian
Registration District No.
Primary Registration District No.
Local Registrar's No. 17
(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Nelson Elam

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cora Elam

6. DATE OF BIRTH (month, day and year) May 28, 1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Locust Knoll Iowa

PARENTS

10. NAME OF FATHER George H. Elam
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Locust Knoll Illinois
12. MAIDEN NAME OF MOTHER Elizabeth Burres
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Locust Knoll Missouri

14. Informant Mrs. Cora Elam
(Address) Meridian Idaho Rt 2

15. Filed 11-1, 1930 J F Neal Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1930 to Oct 29, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 11:15 P m.
The CAUSE OF DEATH* was as follows:
apoplexy.
(duration) yrs. mos. 3 hrs
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J F Neal, M. D.
11-1-, 1930 (Address) Meridian Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridan Ida	11-2 1930

20. Undertaker B W Robison
Address Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Hamilton & Stewart

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72922

PLACE OF DEATH

County of Ada
City of Boise

CERTIFICATE OF DEATH

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 311
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME William Bardwell Lyman.

(a) Residence. No. 1405. West Washington. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Bertha. A. Lyman.

6. DATE OF BIRTH (month, day and year) May. 8. 1855.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75.	6	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physivian.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lansing, Iowa.

PARENTS

10. NAME OF FATHER Tomothy Lyman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chester. Mass.
12. MAIDEN NAME OF MOTHER Valeria Rinehart.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Fort Madison. Iowa.

14. Informant Mrs. Bertha. A. Lyman.
(Address) 1405. W. Washington St. Boise.

15. Filed 12-8, 1930 Wm. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 8 (Month) 13 (Day) 6 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1930, to Dec 6, 1930
that I last saw him alive on Dec 6, 1930
and that death occurred, on the date stated above, at 11-45 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis
Sclerosis coronary artery
Heart.
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) O. P. Hamilton, M. D.
Dec. 8, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Dec. 9. 1930
20. Undertaker	Address
Summers & Krebs. Boise,	Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72923

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. St Luke's Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 310

JAN 10 1931

2. FULL NAME Roy Edward Langley
(a) Residence. No. ..... St. Nampa Ida Rt 2
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Josie Langley

6. DATE OF BIRTH (month, day and year) Mch 28, 1878

7. AGE Years 52 Months 8 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Peoria Ill

PARENTS
10. NAME OF FATHER Richard W Langley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emma Pepper
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant Mrs. Josie Langley
(Address) Nampa Ida Rt 2

15. Filed 12-8, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH 117

16. DATE OF DEATH Dec (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8 December 14 1930, to December 8, 1930 that I last saw him alive on Dec. 8, 1930 and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:
Gangrenous appendicitis
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Mesenteric Thrombosis
(duration) ..... yrs. ..... mos. ½ ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Dec 4, 1930
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Harold W. Stone, M. D.
12/8, 1930 (Address) Eastman Bldg. Boise

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Meridian Ida — Date of Burial 12-11 1930

20. Undertaker B. W. Robison — Address Meridian Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72924

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 309

(No. St. Alphonsus Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 16 1931

2. FULL NAME Bernard Driscoll

(a) Residence. No. ..... St. Fruitland

(Usual place of abode.)

Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 2-1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fruitland, Ida

PARENTS

10. NAME OF FATHER John Driscoll

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Anna Elizabeth Scholer

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant John Driscoll
(Address) Fruitland, Ida

15. Filed 12-8, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 128

16. DATE OF DEATH Dec. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-29, 1930, to 12-6, 1930 that I last saw him alive on 12-6, 1930 and that death occurred, on the date stated above, at 10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Fallopian cold in head

(duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? Fruitland Ida

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) F W Almond, M. D.

12-6, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal	Date of Burial
Ontario Oregon	12/8 1930
20. Undertaker	Address
Schreiber & McCann	Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72925

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 308
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Vera Loraine Skeen.

(a) Residence. No. 92 St. Middleton, Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of William Skeen.

6. DATE OF BIRTH (month, day and year) Feb. 16. 1907.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	9	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairfield, Idaho.

PARENTS

10. NAME OF FATHER Edward Gull.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Clarice. M. Farnsworth

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois.

14. Informant William Skeen.
(Address) Middleton, Idaho.

15. Filed 12-8, 1930 W. I. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27, 1930, to Dec. 5, 1930
that I last saw her alive on Dec 5, 1930
and that death occurred, on the date stated above, at 7 30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pulmonary Embolus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Rt. Ankle

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? On highway.
Did an operation precede death? Yes Date of Nov 28.
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy.

(Signed) Ernest T. Jokerst M.D.
12-6-, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Star Cemetery	12-8 1930
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 12926

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 302

(No.) Near Howard Street, South Boise. 90

(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Lee Warder

(a) Residence. No. Near Howard Street, South Boise.

(Usual place of abode.)

(If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 66			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ky.

PARENTS

10. NAME OF FATHER Jessie Warder.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Mollie Williams.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant Clarence Warder.
(Address) Slaton, Tex.

15. Filed 12-4, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 25th or 26th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---------- 19--, to ---------- 19--
that ~~I last saw him alive on~~ ---------- 19--
and that death occurred, on the date stated above, at ---- m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Found dead. Probably
Acute Heart attack.
Natural Cause.
No Inquest Held.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Had been dead
Probably 36 hours when
found. Body
(duration) mos. ds.

18. Where was disease contracted if not at place of death? found Nov 25-1930.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm McBratney, Coroner M. D.

11/28/30. 19.. (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/4/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7927

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 306
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Viola Redford Mix.

(a) Residence. No. Caldwell, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

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PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) August 5th 1886

7. AGE Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
44	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Nurse.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fossil, Oregon.

PARENTS

10. NAME OF FATHER W. F. Redford.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Sarah V. Finley.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wash.

14. Informant J. A. Redford.
(Address) Austin, Oregon.

15. Filed 12-2-30 (W. N. Rhodes) Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ---- ~~19--~~, to ---- ~~19--~~ ~~that I last saw him~~ alive on ---- ~~19--~~ ~~and that~~ death occurred, on the date stated above, at 6:20P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Suicide. Shot herself in head with 32 Automatic Revolver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No Inquest Held.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ----
Did an operation precede death? No Date of ----
Was there an autopsy? No.
What test confirmed diagnosis? ----

(Signed) Wm McBratney Coroner M. D.
12/2/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/2/30 19

20. Undertaker	Address
Wm. McBratney.	Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72526

PLACE OF DEATH

County of Ada
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 3-5
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)
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RECEIVED JAN 19 1931

2. **FULL NAME** James. A. Shoemaker.

(a) Residence. No. ..... St. Billings Montana.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Carrie. M. Shoemaker.

6. DATE OF BIRTH (month, day and year) October. 18.1866.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	1	12.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Field Represenative
(b) General nature of industry, business, or establishment in which employed (or employer) Oregon Trail Memorial Association.
(c) Name of employer

9. BIRTHPLACE (city or town) Penn.
(State or country)

PARENTS

10. NAME OF FATHER David Shoemaker.

11. BIRTHPLACE OF FATHER (city or town) Penn.
(State or Country)

12. MAIDEN NAME OF MOTHER Mary. M. Evans.

13. BIRTHPLACE OF MOTHER (city or town) Penn.
(State or County)

14. Informant Mrs. J.A. Shoemaker
(Address) Billings Montana. 1114 N/ 31. St.

15. Filed 12-1, 1930 W.V. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1930, to Nov 30, 1930
that I last saw him alive on Nov 30, 1930
and that death occurred, on the date stated above, at 8.30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) ....yrs. ....mos. 15 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ....yrs. ....mos. 15 ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W.A. Forbush, M. D.
12-1, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Billings Montana.	Dec. 4.30
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72929

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 0804
Local Registrar's No. 333
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Clinton Hallet Tyler

(a) Residence. No. 1111 Euclid Ave St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 29 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Adeline Tyler

6. DATE OF BIRTH (month, day and year) Aug 28 - 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	3	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Road Grading
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cape Cod Mass.

PARENTS

10. NAME OF FATHER Philo Tyler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cape Cod Mass.
12. MAIDEN NAME OF MOTHER Nat O Blainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Thomas Mass

14. Informant (Address) C C Tyler 15-12 Broadway

15. Filed 12-1, 1930 W. T. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Nov 29, 1930, that I last saw him alive on about Nov 15, 1930 and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis + Chronic Myocarditis

(duration) 10 yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? Place of Death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. H. Brayton M.D.
Dec 1, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery	12/1 1930

20. Undertaker Schreiber & McCann Address Boise, I.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72930

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 9
Primary Registration District No. 1004
Local Registrar's No. 30
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Marvin D. Mix

(a) Residence. No. 616 North 16th St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lela Mix

6. DATE OF BIRTH (month, day and year) November 18-1885

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	0	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Walla Walla Co. Washington

PARENTS

10. NAME OF FATHER William A. Mix
11. BIRTHPLACE OF FATHER (city or town) (State or Country) U. S. A.
12. MAIDEN NAME OF MOTHER Elizabeth Wiggins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) U. S. A.

14. Informant Laurence B. Mix
(Address) Baker Oregon

15. Filed 12-1, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 197

16. DATE OF DEATH Nov - 29 (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-28-30, to 11-29-30, that I last saw him alive on 11-29-30 and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Gun Shot wound through the Liver
Homicide

(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Shock & Hemorrhage
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? yes Date of 11/29/30
Was there an autopsy? no
What test confirmed diagnosis? Surgical operation
(Signed) Surgeon, M. D.
11/30, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Colton, Wash. Date of Burial 11/30 1930

20. Undertaker: Schreiber & McCann Address Boise, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72931

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 113
(No. Barber Bridge 6 miles east of Boise.
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Maria Uribe
(a) Residence. No. Franklin District St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Poly Uribe

6. DATE OF BIRTH (month, day and year) Dec 8 1908

7. AGE Years 22 Months — Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Boise
(State or country) Ida

PARENTS
10. NAME OF FATHER Joseph Zabala
11. BIRTHPLACE OF FATHER (city or town) Liquertio
(State or Country) Spain
12. MAIDEN NAME OF MOTHER Gloria Madareta
13. BIRTHPLACE OF MOTHER (city or town) Liquertio
(State or County) Spain

14. Informant (Address) Anastasio Jojo Boise Ida

15. Filed 12-30, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 1880

16. DATE OF DEATH Dec. 25-1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19....., to ....., 19.....
~~that I last saw h~~ ..... alive on ....., 19.....
~~and that~~ death occurred, on the date stated above, at about 4. P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Auto Accident. Accidental.
Car in which deceased was riding as a passenger ran off the Barber Bridge over Boise River.
(duration) ..... yrs. ..... mos. ..... ds.
Deceased was killed instantly beneath the Car.
CONTRIBUTORY (Secondary) No Inquest held.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W. McBratney Coroner M. D.
Dec 26, 1930. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal St. John's Cemetery
Date of Burial 12/27 1930

20. Undertaker Schreiber & McCann
Address Boise, Ida

MARGIN RESERVED FOR BIRTH

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72932

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 112
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Richmond Curtis
(a) Residence. No. Collister Home Valley Road (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

RECEIVED JAN 10 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1863

7. AGE About Years 67 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER E. J. Curtis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Am.
12. MAIDEN NAME OF MOTHER Louise ?
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Am.

14. Informant (Address) Geo Collister

15. Filed 12-23 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH Dec. 16 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21, 1930, to Dec. 16, 1930
that I last saw him alive on Dec 16, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Collister, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Pioneer Cemetery
Date of Burial 12/18 1930

20. Undertaker Schreiber & McCann
Address Boise, Ia

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72933

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 111
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 1[illegible] 193[illegible]

2. FULL NAME Thomas Rultedge Jolley.

(a) Residence. No. 6 Miles west of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie . Jolley

6. DATE OF BIRTH (month, day and year) Dec. 31. 1863.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	II	I5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Farmington Utah

PARENTS
10. NAME OF FATHER John Jolley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Hannah. Rutledge
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Scotland.

14. Informant (Address) Mrs Annie M. Jolley. R.F.D.# I. Boise Idaho.

15. Filed 12-22 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 15th 1930. (Month) (Day) (Year) 129

17. I HEREBY CERTIFY, That I attended deceased from July 27 1929, to Dec. 15th 1930, that I last saw h[illegible] alive on Dec. 15 1930, and that death occurred, on the date stated above, at 6 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(duration) 5 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) — yrs. 2 mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) A. L. Goodheart M. D.
Dec 18, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Dec. 19 1930
20. Undertaker: Summers & Krebs. Address: Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72934

PLACE OF DEATH
County of Ada.
City of Eagle.
Registration District No. 2
Primary Registration District No. 2004. Local Registrar's No. 110
(No. Ranch on Eagle Island. 14 Miles W.) of Boise.
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Theodore Dahlman.

(a) Residence. No. 14 Miles W. of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Denmark.
(State or country)

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) "
(State or County)

14. Informant J. C. Blair.
(Address) Eagle, Idaho.

15. Filed 12-22-30 W. N. Rhodes
Registrar.

MEDICAL CERTIFICATE OF DEATH 181

16. DATE OF DEATH Body found Dec 19 1930. Death probably was Dec 17 1930.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ---------- 19--, to ---------- 19--, that I last saw h-- alive on ---------- 19--, and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead in his Auto. Monoxide Gas was probably Cause of Death. Body had been Dead about 36 hours when
(duration) ....yrs. ....mos. ....ds.
found.
CONTRIBUTORY (Secondary) Probably Suicide
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ----------
Did an operation precede death? No. Date of ----------
Was there an autopsy? No.
What test confirmed diagnosis? ----------
(Signed) Wm McBratney, Coroner, M. D.
12/22/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	12/22/30 19
20. Undertaker Wm. McBratney.	Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72935

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 8
Primary Registration District No. 2004
Local Registrar's No. 109
(No. Boise, Idaho. R.#2)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Lewis.

(a) Residence. No. Boise, Idaho R.#2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Addie Lewis.

6. DATE OF BIRTH (month, day and year) May 2nd 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Iowa.
(State or country)

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) "
(State or Country)

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) "
(State or County)

14. Informant Mrs. Addie Lewis.
(Address) Boise, Idaho.

15. Filed 12-19-30 (C.H. Rhodes) Registrar.

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH December 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4th 1930, to Dec 18th 1930, that I last saw him alive on Dec 17th 1930, and that death occurred, on the date stated above, at 1:10 Am.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis & Chronic nephritis (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms

(Signed) A. M. Taylor, M. D.
12/18/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Meridian Cemetery.	12/21/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72936

PLACE OF DEATH

County of Ada.
City of Boise.
Registration District No.
Primary Registration District No. 2004
Local Registrar's No. 108
(No. Idaho State Penitentiary.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edgar P. Huffman

(a) Residence. No. Boise, Idaho. St. 90
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Lula Huffman.

6. DATE OF BIRTH (month, day and year) July 8th 1868

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Guard at Penitentiary.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairfield, Iowa.

PARENTS

10. NAME OF FATHER John W. Huffman.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Eudora Beale.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) Mrs. Bertha Colvin. Boise, Idaho.

15. Filed 12-17, 1930 W. H. Rhodie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 15th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1930, to Dec 15, 1930, that I last saw him alive on Dec 13, 1930, and that death occurred, on the date stated above, at 4:20 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Malarial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) O H Parker, M. D.
12/15/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/18/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 8
Primary Registration District No. 2004 Local Registrar's No. 105
(No. Boise, Idaho R. #1.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931
90

2. FULL NAME Mrs. Lula M. Sabin.
(a) Residence. No. Boise, Idaho. R#1. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: D. C. Sabin.

6. DATE OF BIRTH (month, day and year): Feb. 7th 1876

7. AGE: Years 54, Months 9, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Mason Co. Ill.

PARENTS

10. NAME OF FATHER: E. W. Atwater.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: E. Z. White.
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Cleveland, Ohio.

14. Informant (Address): D. C. Sabin. Boise, Idaho. R#1.

15. Filed 12-1, 1930 W. H. Rhode Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 25th 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ....., 19..., to ....., 19...
~~that I last saw her alive on~~ ....., 19...
~~and that~~ death occurred, on the date stated above, at 2:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Heart Disease.
Dropsy.
Sick for over 1 yr. (duration) yrs. mos. ds.
No Medical Doctor in attendance before death.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
Natural Cause.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? No.
What test confirmed diagnosis? —
(Signed) Wm McBratney Coroner, M. D.
11/26/30, 19... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Parma, Idaho. Date of Burial: 11/28/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE ✓
State File No. 72938

PLACE OF DEATH

County of Ada.
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 333
(No. St. Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

101a

2. FULL NAME Dean Curtis Williams.
(a) Residence. No. Mountain View Apts. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 8 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

JAN 10 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) July 3rd 1912.

7. AGE Years 18 Months 5 Days 15 If LESS than 1 day, ... hrs. or ---------- min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work High School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cheney, Kansas.

PARENTS

10. NAME OF FATHER R. G. Williams.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.
12. MAIDEN NAME OF MOTHER Donna Brockman.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri.

14. Informant (Address) Mrs. R. G. Williams. ~~Boise, Idaho.~~

15. Filed 12-19, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 18th 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 18, 1930
that I last saw him alive on Dec 18, 1930
and that death occurred, on the date stated above, at 4:45 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Double pneumonia

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no (microscopic)
What test confirmed diagnosis? Clinical X ray
(Signed) W. L. Frazier M. D.
12/19/30, 19..... (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 12-20-30 19

20. Undertaker Wm. McBratney.
Address Boise, Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7293

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 332
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eugene D. Koontz

(a) Residence. No. Council, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Katie Koontz.

6. DATE OF BIRTH (month, day and year) March 24th 1862

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	8	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Night watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Gilbert Koontz.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Sarah E. Hickson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ky.

14. Informant Doris Koontz.
(Address) Boise, Idaho.

15. Filed 12-19, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 880

16. DATE OF DEATH December 18th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-12-, 1930, to 12-18-30, that I last saw him alive on 12-18-30, and that death occurred, on the date stated above, at 11:30 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
(Auricular Fibrillation)
Chronic Aortitis, Coronary
Sclerosis. (duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) - Chronic Myocarditis -
Decompensation (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? yes.
What test confirmed diagnosis? - Autopsy
(Signed) Ernest E. Lambaugh, M. D.
12/18/30, 19 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal: Council, Idaho. Date of Burial: 12/20/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO Genoway

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72940

PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 21

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number)

JAN 10 1931

74B

2. **FULL NAME** Alice Harriet Rudge.

(a) Residence. No. 2706. Main Street. St.

(Usual place of abode.)

Length of residence in city or town where death occured. 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 28. 1857.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.	11	19.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Exira, Iowa.
(State or country)

PARENTS

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (city or town) Unknown.
(State or Country)

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or County)

14. Informant Lem Rudge.
(Address) R.D. # 3. Boise, Idaho.

15. Filed 12-18 1930 W. H. Rhoades
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to Dec 17, 1930
that I last saw her alive on Oct. 24, 1930
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Hemiplegia from
Cerebral Embolism and Thrombosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) Chas. V. Genoway, M. D.
Dec 17, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Joplin Cemetery.	Dec. 19. 30.
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Call 130 when ready

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72942

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 319
(No. St. Alphonsus Hospital) 49
(If death occurred in a hospital or institution, give its name instead of street and number.)
JAN 10 1931

2. FULL NAME John C. Connors
(a) Residence. No. Silver City 64 years. St. Jordan Valley, Ore.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in ~~city~~ or town where death occured. yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Theresa Connor

6. DATE OF BIRTH (month, day and year) February 11-1859

7. AGE Years 71 Months 9 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) California

PARENTS
10. NAME OF FATHER Peter Connor
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) D. P. Connors Jordan Valley Ore

15. Filed 12-18, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Dec 3, 1930
that I last saw h..... alive on Nov 30, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Pharynx

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Jordan Valley Ore
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Lemeah Stewart M. D.
12/13, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal St. John's Cemetery
Date of Burial 12/6 1930

20. Undertaker Schreiber & McCann
Address Boise

Stewart

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12943

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 378
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Ora Florence Hayden.

(a) Residence. No. 420. S. 12 th Street. St. Anderson Missouri.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Willard. M. Hayden.

6. DATE OF BIRTH (month, day and year) September. 1. 1868.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	3	14.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Illinois. (State or country)

PARENTS

10. NAME OF FATHER A.F. Morris.
11. BIRTHPLACE OF FATHER (city or town) Illinois. (State or Country)
12. MAIDEN NAME OF MOTHER Thomas.
13. BIRTHPLACE OF MOTHER (city or town) Indiana. (State or County)

14. Informant Mrs. May Bell.
(Address) 420. S. 12. St Boise Idaho.

15. Filed 12-16, 1930 W.N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 10 1a

16. DATE OF DEATH Dec. (Month) 15 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 15, 1930, that I last saw her alive on Dec 15, 1930 and that death occurred, on the date stated above, at 1115 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia (Lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
— (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P.P. French, M. D.
Dec. 15, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill — Date of Burial: 12-17 1930
20. Undertaker: Summers & Kreig — Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO Dr Forney. [illegible]

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 72944

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 317
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

JAN 16 [illegible]

2. FULL NAME Delia Cuddy.
(a) Residence. No. 1204. N. 11 Street. St. 164
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March. 15.1844.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
86	9	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER Edward Tyne.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.
12. MAIDEN NAME OF MOTHER Nellie Doran.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland.

14. Informant (Address) John Cuddy. 1204. N. 11. St. Boise, Idaho.

15. Filed 12-16, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec - 15, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec 15, 1930
that I last saw her alive on Dec 15, 1930
and that death occurred, on the date stated above, at 5,30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? usual
12/16 (Signed) Susomey, M. D.
1930 (Address) Boise Ida

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery
Date of Burial: Dec 19 1930

20. Undertaker: Summers & Krebs, Boise, Idaho.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72945

PLACE OF DEATH
County of Ada.
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 316
(No. Salvation Army Rescue Home.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Betty Grace Houghton
(a) Residence. No. 2416 Hazel Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured - yrs. 2 mos. 19 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ----------
6. DATE OF BIRTH (month, day and year) September 24th 1930
7. AGE Years 0 Months 2 Days 19 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS
10. NAME OF FATHER Sidney Houghton.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Worcester, England
12. MAIDEN NAME OF MOTHER Delores Buchanan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Boise, Idaho.

14. Informant (Address) Mrs. Sidney Houghton. Boise, Idaho.

15. Filed 12-15, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 100a

16. DATE OF DEATH December 13th 1930, 19.... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 13, 1930
that I last saw her alive on Dec 13, 1930
and that death occurred, on the date stated above, at 10:30 A.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(only saw child once about one hour before death)
..... (duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (Secondary) Toxaemia
..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Bratney, M. D.
12/15/30, 19.... (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial 12/15/30, 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 72946

PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

Local Registrar's No. 315

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Thomas Lewis Bennett.

(a) Residence. No. 1304. N. 18 Street. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephene Bennett.

6. DATE OF BIRTH (month, day and year) July. 31.1855.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75.	4	12.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Real Estate and Loans.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER Silas. W. Bennett.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Elizabeth Duke.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland.

14. Informant Mrs. Josephene Bennett.
(Address) 1304. N. 18 Street, Boise, Idaho.

15. Filed 12-15 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 21

16. DATE OF DEATH Dec. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Dec 6, 1930,
that I last saw him alive on Dec 5, 1930,
and that death occurred, on the date stated above, at 9.40 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Erysipelas,

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) S. W. Anderson, M.D.
Dec 6, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery,	Dec. 14. 30.

20. Undertaker Summers & Krebs Address Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72947

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 24
(No. St. Alphonsus Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

JAN 10 '33

2. FULL NAME Georgie Franklin Brown
(a) Residence. No. ..... St. Eagle, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) September 26-1919

7. AGE Years 11 Months 2 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wittman Co. Washington

PARENTS
10. NAME OF FATHER George W. Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Ella Bass
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant (Address) G. W. Brown

15. Filed 12-11, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH Dec. (Month) 9 (Day), 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1930, to Dec 9, 1930
that I last saw him alive on Dec 8, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(double)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) [signature], M. D.
Dec 10, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Nampa, Ida
Date of Burial 12-11, 193

20. Undertaker Schreiber & McCann
Address Boise Ida

Dr. Collister on Holveson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72948

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 313
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Mary E. Kinkaid
(a) Residence. No. 606 State St. 88a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John Kinkaid

6. DATE OF BIRTH (month, day and year) April 13 1852

7. AGE Years 78 Months 7 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Emerson E Barter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rochester New York
12. MAIDEN NAME OF MOTHER Ester McNight
13. BIRTHPLACE OF MOTHER (city or town) (State or County) U.S.A.

14. Informant (Address) C. M. Fife

15. Filed 12-10, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Dec 6, 1930
that I last saw her alive on Dec 6, 1930
and that death occurred, on the date stated above, at 11 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Coronary Emboli-
(asthma
Endocarditis)
Instantaneous
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) asthma-Endocarditis
Many Years (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French, M. D.
12-8, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery
Date of Burial 12/9 1930

20. Undertaker Schreiber & McCann
Address Boise, I

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72949

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. Eastman Bldg.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 312

90

2. FULL NAME Barry Cronin
(a) Residence. No. Overland Hotel St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 32 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) — — —

7. AGE Years About 62 | Months | Days | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) County Cork Ireland

PARENTS
10. NAME OF FATHER John Cronin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Angel Leary
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) John J Hanning
Caldwell Ida Rt

15. Filed 12-10, 1936 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 7th or 8th 1930. (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ~~19~~, ~~to~~ ~~19~~
~~that I last saw h~~ ~~alive on~~ ~~19~~
~~and that~~ death occurred, on the date stated above, at ___ m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead. Probably acute heart attack.
Natural Cause.
No Inquest Held.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) W McBrahney Coroner, M. D.
12/9 - 1930., 19 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal St Johns Cemetry
Date of Burial Dec 10 1930

20. Undertaker Schreiber & McCann
Address Boise Ida

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7295

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1005 Local Registrar's No. 154
(No. St Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Dr. John W. Gue

(a) Residence. No. 1510 Cleveland St. Caldwell Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Emma Gue

6. DATE OF BIRTH (month, day and year) 7-25 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician & Surgeon
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Toulon Ills
(State or country)

PARENTS

10. NAME OF FATHER John Gue

11. BIRTHPLACE OF FATHER (city or town) Ills
(State or Country)

12. MAIDEN NAME OF MOTHER Roberts

13. BIRTHPLACE OF MOTHER (city or town) Ohio
(State or County)

14. Informant Mrs J.W.Gue
(Address) 1510 Cleveland Caldwell Ida

15. Filed 12-31-, 1930. John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26 1930 5813
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-17-30, 19..., to 12-26-30, 19...
that I last saw h— alive on 12-25-30, 19...
and that death occurred, on the date stated above, at 12 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Aplastic Anemia

(duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY (Secondary) Chronic Infections

Arthritis (duration) 3 yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? Caldwell, Ida.
Did an operation precede death? no Date of
Was there an autopsy? no What test confirmed diagnosis? Blood Studies
(Signed) Ernest E. Bachman M. D.
12/30/, 1930 (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill Cemetery	12-28-30 19

20. Undertaker	Address
Paul L. Case	Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Frasure

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72951

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
(No. 620 Fort St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 341

RECEIVED JAN 10 1931

2. FULL NAME John Lesh
(a) Residence. No. Nampa Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male ~~Female~~
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 19 1852
7. AGE 78 Years Months 1 Days 6 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) ~~Ohio~~ Indiana

PARENTS
10. NAME OF FATHER Christian Lesh
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Nancy Flora
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant Mrs J.W.Briggs
(Address) 620 Fort St. Boise, Idaho
15. Filed 12-31, 1930 W. H. Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25 1930 10/a 19
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to Dec 25, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Double Pneumonia
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W R Frazier, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kohlerlawn Cem. Nampa
Date of Burial 12/28/30 19
20. Undertaker Fred K. Robinson
Address Nampa, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Stone

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72952

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 340
(No.) St Alphonsus Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Frank Atwood Rinehart

(a) Residence. No. 708 Hays St. 88a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 17, 1905

7. AGE: Years 25 | Months 4 | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bank Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Pittsburg Penn

PARENTS

10. NAME OF FATHER: Frank G Rinehart
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Harriet Church
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Penn

14. Informant (Address): Harriet Rinehart 708 Hays St Boise Idy

15. Filed 12-31-30 W. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 30, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1930, to December 30, 1930
that I last saw h— alive on Dec. 30, 1930
and that death occurred, on the date stated above, at 12 05 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
with Decompensation

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Harold W Lowe, M. D.
12/31, 1930 (Address) Eastman Bldg Boise

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery — Date of Burial: Jan 2 1931

20. Undertaker: Summers & Kreft — Address: Boise Idy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72953

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 339
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Mary Elizabeth Sargent.

(a) Residence. No. 1502. N. 21. Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 12 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Colby. A. Sargent.

6. DATE OF BIRTH (month, day and year) September. 6. 1865.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	3	24.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marietta Ohio.

PARENTS

10. NAME OF FATHER Benjamin. G. Lewis.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.

12. MAIDEN NAME OF MOTHER Mary Grimes.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant Colby. A. Sargent.
(Address) 1502. N. 21. Streetm Boise, Ida.

15. Filed 12-31-1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 8813

16. DATE OF DEATH December 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26, 1928 to 12-30, 1930
that I last saw her alive on 12-30, 1930
and that death occurred, on the date stated above, at 4-45 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Ascites -
Sclerosis of liver -
Myocarditis.
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis
general (duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No What test confirmed diagnosis? Aspiration for ascites

(Signed) W. Jas. L. Stewart M. D.
Dec. 30, 1930 (Address) Life-O-Plasm Bldg. Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Dec. 31. 30.
20. Undertaker	Address
Summers & Krebs, Boise, Idaho.	

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72954

PLACE OF DEATH
County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1014
Local Registrar's No. 338
(No. 2211 N. 16th Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Julia Ulrich

(a) Residence. No. 2211 N. 16th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of George Ulrich

6. DATE OF BIRTH (month, day and year) November 20th 1845

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10. NAME OF FATHER Jacob Hyde.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Elizabeth Baker.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant B. H. Hyde.
(Address) Oreana, Idaho.

15. Filed 12-30, 1930 C. A. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 1113

16. DATE OF DEATH December 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930 to Dec 29, 1930
that I last saw her alive on Dec 29, 1930
and that death occurred, on the date stated above, at 11:40 P

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. M. Bratton, M. D.
12/30/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/31/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72955

PLACE OF DEATH
County of Ada.
City of Boise.
Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 337
(No. 1116 Miller Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emanuel Buckner.

RECEIVED JAN 10 90

(a) Residence. No. Homedale, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	Negro.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella M. Buckner.

6. DATE OF BIRTH (month, day and year) November 28th 1863

7. AGE Years	Months	Days	If LESS than 1 day, ---hrs. or ---min.
67	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Marion Co. Mo.

PARENTS

10. NAME OF FATHER David N. Buckner.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Laura----------
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant (Address) Mrs. Ella M. Buckner. Homedale, Idaho.

15. Filed 12-30, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 28th 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27th, 1930, to Dec 28th, 1930, that I last saw him alive on Dec 28th, 1930 and that death occurred, on the date stated above, at 8:30 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dilatation of heart - due
to Hypertrophy of heart under-
lying valvular lesions -
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Asthma for about 12 years
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) [signature] M. D.
12/29/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 1/2/31 19
Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72956

PLACE OF DEATH

County of Ada.
City of Boise.

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 336
(No. St. Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Gladys Irene Stewart.

(a) Residence. No. 1122 Michigan St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6. DATE OF BIRTH (month, day and year) April 9th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	8	19	----------

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS

10. NAME OF FATHER Leonard Stewart.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas.
12. MAIDEN NAME OF MOTHER Madeline Reagan.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon.

14. Informant Leonard STewart.
(Address) Boise, Idaho.

15. Filed 12-30 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 100a

16. DATE OF DEATH December 28th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1930, to Dec 28 1930, that I last saw her alive on Dec 28 1930 and that death occurred, on the date stated above, at 5:45 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Double bronchio
pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Coryza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C.W. Bosch, M. D.
12/29/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 12/29/30 19

20. Undertaker: Wm. McBratney. Address: Boise, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. Budget 9 Calloway 129

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 335
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Margaret Gedye Thompson.

(a) Residence. No. 314. State Street. St. 74a
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Widow.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) January. 18. 1856.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74.	11	10.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Mineral Point.
(State or country) Wisconsin.

PARENTS

10. NAME OF FATHER
William Gedye.

11. BIRTHPLACE OF FATHER (city or town) England.
(State or Country)

12. MAIDEN NAME OF MOTHER
Mary Mc Muldan.

13. BIRTHPLACE OF MOTHER (city or town) Ireland.
(State or County)

14. Informant Mrs. Hattie Wilkinson.
(Address) 314. State Street, Boise, Idaho.

15. Filed 12-29, 1930 W. N. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 28, 1930, to Dec 28, 1930
that I last saw her alive on Dec 27, 1930
and that death occurred, on the date stated above, at 9:15A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Chicago
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. Conaway Jr. Jubic, M. D.
Dec 29, 1930. (Address) Boise, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Dec. 30. 1930
20. Undertaker	**Address**
Summers & Krebs, Boise,	Idaho.

Springer

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72953

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 334
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 10 1931

2. FULL NAME Thomas Ogden.

(a) Residence. No. 1015. N. 20 Street. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Elsie Burr Ogden.

6. DATE OF BIRTH (month, day and year) Nov. 5. 1868.

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	1	22.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Auditor and Bookkeeper.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Yorkshire England.
(State or country)

PARENTS

10. NAME OF FATHER John Ogden.
11. BIRTHPLACE OF FATHER (city or town) England.
(State or Country)
12. MAIDEN NAME OF MOTHER Martha Booth.
13. BIRTHPLACE OF MOTHER (city or town) England.
(State or County)

14. Informant Mrs. Elsie Burr Ogden.
(Address) 1015. N. 20. Street, Boise, Idaho

15. Filed 12-29 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH Dec. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24, 1930, to Dec 27, 1930, that I last saw h— alive on Dec 26 1930 and that death occurred, on the date stated above, at 10:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY —
(Secondary)
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? "
Did an operation precede death? No Date of —
Was there an autopsy? Yes.
What test confirmed diagnosis? autopsy.

(Signed) J D Springer, M. D.
Dec 29, 1930. (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Morris Hill Cemetery.	Dec. 29.30.
20. Undertaker	Address
Summers & Krebs, Boise,	Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72959

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 333
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Rodger Pinney
(a) Residence. No. 200 [illegible] Building St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of James A Pinney
6. DATE OF BIRTH (month, day and year) Sept 24 th 1857
7. AGE Years 73 Months 3 Days 1 If LESS than 1 day hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Salem Oregon

PARENTS
10. NAME OF FATHER Alexander Rodger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Glasgow Scotland
12. MAIDEN NAME OF MOTHER Isabel
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Edinburg Scotland

14. Informant (Address) Mrs. W. A. Mendenhall 1007 N. 6th Boise Idaho
15. Filed 12-27, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 120

16. DATE OF DEATH 12 (Month) 23 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec. 25, 1930
that I last saw her alive on Dec 24, 1930
and that death occurred, on the date stated above, at m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute yellow atrophy of liver
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Geo Collister M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal Pioneer Cemetery Date of Burial Dec 27 1930
20. Undertaker Schreiber & McCann Address Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72960

PLACE OF DEATH

County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 331
(No. 421 South 13th)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Melville J. Anderson
(a) Residence. No. 421 South 13th St. 107
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Anderson

6. DATE OF BIRTH (month, day and year) July 30th 1860

7. AGE Years 70 Months 4 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Terry County, Indiana.

PARENTS

10. NAME OF FATHER John R. Anderson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown.
12. MAIDEN NAME OF MOTHER Mary Stevenson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio.

14. Informant (Address) Mrs. Laura Anderson. Boise, Idaho.

15. Filed 12-26, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 25th 1930, 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1930, to Dec 25th, 1930
that I last saw him alive on Dec. 24th, 1930
and that death occurred, on the date stated above, at 4 A.M.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Oedema of lungs and general dropsy
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Bright's disease and valvular heart lesions for years (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) John Bouch M. D.
12/26/30, 19 (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Date of Burial 12/28/30 19

20. Undertaker Wm. McBratney. Address Boise, Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 1226 E. Jefferson St.)

State File No. 72864
Local Registrar's No. 330
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ross Wesley Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan 26 - 1881 (Month) (Day) (Year)

7. AGE: 49 Yrs. 10 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bookkeeper and
(b) General nature of industry, business or establishment in which employed (or employer): office manager.

9. BIRTHPLACE (State or Country): Sommerton Ohio

10. NAME OF Father: John D. Jackson.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sar-Morgi Nicol

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. R. W. Jackson
(Address) 1226 E Jefferson St Boise Id

15. Filed 12-26 1930 W. H. Rhodes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1930 (Year) 92

17. I HEREBY CERTIFY, That I attended deceased from April 1926 to Dec 25 1926, that I last saw him alive on Dec 25 1930, and that death occurred on the date stated above, at 5:30 a M.

The CAUSE OF DEATH* was as follows:
Thrombosis of right vertebral artery partial thrombosis of basal artery
(Duration) 4 yrs. 6 mos. ..... ds.
Contributory (Secondary) paralysis of bowels auto intoxication
(Duration) ..... yrs. ..... mos. 5 ds.
(Signed) O H Parker M. D.
19..... (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? Boise, Ida
Former or usual residence Boise, Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Dec 28 1930

20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. Kelsey 72962

PLACE OF DEATH
County of Ada
City of Boise.

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 329
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 [illegible]

2. FULL NAME Olla Mabel Morrow.
(a) Residence. No. 251. Warm Springs Ave. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Roy Morrow.

6. DATE OF BIRTH (month, day and year) September. 2.1877.

7. AGE Years 53 Months 3 Days 20. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS
10. NAME OF FATHER W.W. Wolcott.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa.
12. MAIDEN NAME OF MOTHER Sylvia Lansberry.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) Roy Morrow. 251. W.S.A. Boise, Idaho,

15. Filed 12-24, 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 105

16. DATE OF DEATH Dec (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1930, to Dec 9, 1930, that I last saw her alive on Dec 9, 1930 and that death occurred, on the date stated above, at 9 am.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Respiratory Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? usual
(Signed) Dutomey M. D.
12/24, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery Dec. 24.1930. Date of Burial 19
20. Undertaker Summers & Krebs, Boise, Idaho. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72963

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 328
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jay Oliver Marquess
(a) Residence. No. 415-S 4-St St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Zona Marquess

6. DATE OF BIRTH (month, day and year) 6/17/1890

7. AGE: Years 40, Months 6, Days 3. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer) Employer
(c) Name of employer

9. BIRTHPLACE (city or town) Kirksville
(State or country) Knox Co. Mo.

PARENTS
10. NAME OF FATHER James Marquess.
11. BIRTHPLACE OF FATHER (city or town) Mo.
(State or Country)
12. MAIDEN NAME OF MOTHER Mary A Miller
13. BIRTHPLACE OF MOTHER (city or town) Edina
(State or County) Mo.

14. Informant (Address) C A B Drake 1312-N-19- Boise Ida.

15. Filed 12-23, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH December (Month) 20 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 20 November 1930, to December 20, 1930
that I last saw him alive on December 20, 1930
and that death occurred, on the date stated above, at 3 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
— (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P. P. French M. D.
Dec 23, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetry
Date of Burial: 12-23 1930

20. Undertaker: Schreiber McCann
Address: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

72964

PLACE OF DEATH

County of Ada
City of Boise

Registration District No. 3
Primary Registration District No. 1004 Local Registrar's No. 327
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME George. W. Lewis.
(a) Residence. No. Council Idaho. St. Council Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male.
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Jennie. C. Lewis.

6. DATE OF BIRTH (month, day and year) February. 241850.

7. AGE Years 80. Months 9 Days 28. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana.

PARENTS

10. NAME OF FATHER John Lewis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.
12. MAIDEN NAME OF MOTHER Katherine Kester.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio.

14. Informant (Address) Mrs. Jennie. C. Lewis. Council, Idaho.

15. Filed 12-23 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH 135

16. DATE OF DEATH December 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 30, 1930, to Dec. 22, 1930
that I last saw him alive on 12/21/30, 19..
and that death occurred, on the date stated above, at 3:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic hypertrophied Prostate -
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - (Uremia) (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam. 4 Laboratory work [illegible]
(Signed) [illegible] M. D.
12-22-30 19.. (Address) Boise, Idaho.

19. Place of Burial, Cremation, or Removal Morris Hill Cemetery. Date of Burial Dec. 24. 1930

20. Undertaker Summers & Krebs. Boise, Address Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72965

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004 Local Registrar's No. 326
(No. St Lukes Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Annie Creszentia Scharf.
(a) Residence. No. 905. N. 18 Street. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George Clifton Scharf.

6. DATE OF BIRTH (month, day and year) Aug. 16.1871.

7. AGE Years ~~49~~ 59 | Months 4 | Days 4 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield, Mass.

PARENTS

10. NAME OF FATHER John Fromenwiler.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland.
12. MAIDEN NAME OF MOTHER Anna Von Glahm.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany.

14. Informant (Address) C.G. Scharf. 905. N. 18 Street, Boise, Idaho.

15. Filed 12-22, 1930 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 74B

16. DATE OF DEATH 12 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/30, 1930, to 12/21, 1930
that I last saw her alive on 12/20, 1930
and that death occurred, on the date stated above, at 8 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Embolis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of hip R.
21 days (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Reduction of fracture
Was there an autopsy? no 11/30/30
What test confirmed diagnosis? Clinical findings
(Signed) Fred A Pettinger, M. D.
12/21, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation, or Removal: Springfield, Mass. | Date of Burial: Dec. 26.30.

20. Undertaker: Summers & Krebs. | Address: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72966

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 335
(No. St Alphonsus Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 19[illegible]

2. FULL NAME Frances Luella Shaw.
(a) Residence. No. 3 Miles South West of Boise. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. Single, Married, Widowed, or Divorced (write the word.): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23.1924.

7. AGE Years 6 Months 2 Days 26. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho.

PARENTS
10. NAME OF FATHER Emmett Clyde Shaw.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Z Hazel. F. Glenn.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweet, Idaho

14. Informant (Address) E.C. Shaw. Boise, Idaho. R.D. # 2.

15. Filed 12-20, 1930 W.H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH 117

16. DATE OF DEATH Dec (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1930, to Dec 19, 1930
that I last saw her alive on Dec 19, 1930
and that death occurred, on the date stated above, at 1:00 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis following operation for ruptured appendix operation by Dr. Stone.
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 15
Was there an autopsy? no
What test confirmed diagnosis? Positive
(Signed) H. M. Holverson, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: Dec. 21.1930

20. Undertaker: Summers & Krebs, Boise, Idaho. Address

FORM V. S. No. 5-25 RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 7
Registered No. 2

1. PLACE OF DEATH

County of Bannock
City or (No.) Lava Hot Springs (St.)
If death occurs away from usual residence, give facts called for under special information. Municipal Sanitarium

2. FULL NAME Carmen Salazar Diaz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Mexican	married

6. DATE OF BIRTH Not known (Month) (Day) 1901 (Year)

7. AGE 29 Yrs. Not known Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mexicago

10. NAME OF FATHER Teodoro Salazar

11. BIRTHPLACE OF FATHER (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Bonfacia Navarro

13. BIRTHPLACE OF MOTHER (State or Country) Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raphael Diaz
(Address) Mc Cammon Idaho

15. Filed Jan 5 1931 Mrs G. L. Tift Local Registrar

MEDICAL CERTIFICATE OF DEATH

146

16. DATE OF DEATH December (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1930 to Dec 19 1930 that I last saw her alive on Dec 19 1930 and that death occurred on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:
Toxemia of Pregnancy

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. H. Ricks M. D. M. D.
Dec 19 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 1 days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Mc Cammon

Former or usual residence Mc Cammon, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Lava Hot Springs — Primary Registration District No. 2161

(No. ..... St.)

File No. 72969

Registered No. 201

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joan Carlile

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 22 (Day) 1929 (Year)

7. AGE: 1 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Lava Hot Springs Idaho

10. NAME OF FATHER: Louis Williana Carlile

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Wilda Ray Lyon

13. BIRTHPLACE OF MOTHER (State or Country): Hyde Park Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lew Carlile

(Address) McCammon Ida

15. Filed Jan - 5 - 1931 Mrs. G. G. Fitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

101 a

16. DATE OF DEATH: Dec (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1930, to Dec 28 1930, that I last saw her alive on Dec 28 1930, and that death occurred on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary): Intestinal influenza

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) A. H. Rich M. D.

12-28 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 9 days. In the State ..... yrs. 16 mos. ..... days

Where was disease contracted if not at place of death? McCammon Ida

Former or usual residence McCammon Idaho

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Arthur W. Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

7252

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 190
Registered No. 199

1. PLACE OF DEATH

County of Bannock
City of Lava Hot Springs
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luther Ray Miles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6. DATE OF BIRTH ~~June~~ Jan (Month) 14 (Day) 1917 (Year)

7. AGE 13 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bancroft Idaho

10. NAME OF FATHER Ray R. Miles

11. BIRTHPLACE OF FATHER (State or Country) Paradise Utah

12. MAIDEN NAME OF MOTHER Ama E Potter

13. BIRTHPLACE OF MOTHER (State or Country) Downey Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray R Miles
(Address) Lava Hot Spg. Ida.

15. Filed Jan 5 1931 Mrs G G Fitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1930 (Year) 183

17. I HEREBY CERTIFY, That I attended deceased from on Dec 7 1930 to after noon Dec 7 1930 that I last saw him alive on Dec 7, 1930 and that death occurred on the date stated above, at 9 22 P.M.

The CAUSE OF DEATH* was as follows:
Accidently shot

(Duration) ..... Yrs. ..... mos. 4 hours ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

12-7 1930 (Address) Lava Hot Springs.

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ..... 19.....

20. UNDERTAKER | **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 4297

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bannock
City of Lava Hot Springs

Registration District No. 84
Primary Registration District No. 216 Local Registrar's No. 198
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Rebecca Fife 90

(a) Residence. No. Lava Hot Springs, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wife of William J. Fife

6. DATE OF BIRTH (month, day and year) May 14, 1874.

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Portage, Utah.

PARENTS

10. NAME OF FATHER Charlie John

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Elizabeth Williams

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wales

14. Informant (Address) Mrs. Geo. Wilkinson Logan, Utah.

15. Filed Jan-5- 1931 Mrs G E Fife Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 6, (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Dec 6 1930
that I last saw her alive on Dec 5 1930
and that death occurred, on the date stated above, at 9½ a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Heart trouble

.....(duration) ....yrs. 7 mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? by examination
(Signed) C A Rich, M. D.
12-6-, 1930 (Address) Lava Hot Springs

19. Place of Burial, Cremation, or Removal: Lava Cemetery Lava Hot Springs, Ida. — Date of Burial: 12/8/30. 19

20. Undertaker: Arthur W. Hall Mortuary — Address: Poca., Ida

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12972

PLACE OF DEATH
County of Bannock
City of Bancroft

Registration District No. 84
Primary Registration District No. 2161
(No.)

Local Registrar's No. 197

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Eloize Lloyd Hatch

(a) Residence. No. Bancroft St.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec 8 1930

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		17	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bancroft Ida.

PARENTS

10 NAME OF FATHER Lee Merril Hatch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Idaho

12 MAIDEN NAME OF MOTHER Beatrice Lloyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Idaho

14 Informant Taken from birth record by
(Address) Mrs G.G. Fitz

15 Filed Dec 31, 1930 Mrs G. G. Fitz
Registrar

MEDICAL CERTIFICATE OF DEATH 99C

16 DATE OF DEATH Dec 25 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 1930, to ..., 1930,
that I last saw her alive on ..., 1930,
and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:
Bronchitis
Probably Influenza origin
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) G G Fitz, M. D.
Dec 31, 1930 (Address) Bancroft Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Central Ida	Dec 28 1930
20. Undertaker	Address
Hadmore	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19 JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Lava Hot Springs

Registration District No. 84

Primary Registration District No. 2161

(No. ..... St.)

File No. 12973

Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Landon Lorenzo Rich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1877 (Year)

7. AGE: 53 Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: Landon Rich

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary Florence Bratton

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. C. A. Rich

(Address) Lava Hot Springs Ida

15. Filed Dec - 31 - 1930 Mrs. G. G. Fitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1930 (Year) 89

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1930, to Dec 2 1930, that I last saw him alive on Dec 2 1930, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) None known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Rich M. D.

12-2 1930 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible]

DATE OF BURIAL: 12-5 1930

20. UNDERTAKER: [illegible]

ADDRESS: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7297

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5963
(No. 226 West Lewey St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 16 1931

2. FULL NAME Mary Ann Duncan
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Oct 8, 1848

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
82	2	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Ottumwa (State or country) Iowa

PARENTS
10. NAME OF FATHER Alfred Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Nancy Markham
13. BIRTHPLACE OF MOTHER (city or town) (State or County) West Virginia

14. Informant (Address) Dick Pocatello Ida

15. Filed Dec 17, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH 8813

16. DATE OF DEATH December 16, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-1, 1930, to 12-15, 1930
that I last saw her alive on 12-15 1930
and that death occurred, on the date stated above, at 1.25 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis Chronic
(duration) 10 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No What test confirmed diagnosis? Clinical
(Signed) W. W. Brotherton, M. D.
12-15, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Ida	Dec 18 1930
20. Undertaker L. M. C. Hansen	Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72975

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5964
(No. 172 Hawthorn Ave)
(If death occurred in a hospital or institution, give its name instead of street ~~and number.~~)

JAN 10 1931
90

2. FULL NAME ~~Oral~~ Orval J. Blades
(a) Residence. No. 172 Hawthorn St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth A. Tinsley

6. DATE OF BIRTH (month, day and year): May, 28, 1893

7. AGE: Years 37, Months 6, Days 20. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Nebraska

PARENTS
10. NAME OF FATHER: C.B.Blades
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Ann Packet
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Missouri

14. Informant (Address): Mrs Elizabeth A. Blades

15. Filed 12/18/30, 19.. J R Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December, 16, 1930, 19.. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1930, to Dec 16, 1930
that I last saw him alive on Dec 15, 1930
and that death occurred, on the date stated above, at 10 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Mytral insufficiency - with acute dilatation of the heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis (duration) about 10 yrs. yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) O. F. Reed, M. D.
12/15, 1930 (Address) Pocatello Ida

19. Place of Burial, Cremation, or Removal: Burley Idaho
Date of Burial: Dec., 19 1930

20. Undertaker: Arthur W. Hall Mortuary
Address: Pocatello Idaho

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States Department of Commerce
Bureau of the Census

Amended Jan. 28, 1965

Certificate Of Death

STATE OF IDAHO

State File No. 72976
Local Reg. No. 5965
Reg. Dist. No. 2161

1. **PLACE OF DEATH:**
   (a) County Bannock
   (b) City or town Pocatello
   (c) Street Address or R. F. D. No.
   (d) Death Occured Inside? Outside? city or town
   (e) Died in a Home Hospital Institution Other place
   (f) Name Hosp. or Inst. Pocatello Gen Stayed days
   (g) Lived in this county years months days

Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **Usual Residence of Deceased:** (Always fill in these)
   (a) State Utah (b) County
   (c) City or town Salt Lake City, Utah
   (d) Street Address or R.F.D. No.
   (e) Deceased lived Inside? Outside? city or town
   (f) Citizen of what country?
   (g) How long had deceased lived in Idaho? years
   (h) Former residence (city, state)

3. (a) **FULL NAME** Marcus Frederick Whitman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Martha Jane Whitman

6. (c) Age of husband or wife if alive years

7. Date of Birth (Month, Day, Year) Aug. 2, 1858

8. AGE	Years	Months	Days	If less than 1 day
	72	4	15	hrs min.

9. Exact Occupation Mining Promoter — Did this work for yrs.

10. Industry or Business — Date last worked

11. Birthplace Como, Illinois (City or town) (State or foreign country)

Father
12. Name Edwin C. Whitman
13. Birthplace Mass. (City or town) (State or foreign country)

Mother
14. Maiden name Florence H. Sampson
15. Birthplace Duxbury, Mass. (City or town) (State or foreign country)

16. Informant's **OWN** Signature E. D. Whitman
and Address Soda Springs, Idaho

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-1930 (Month) (Day) (Year)
(c) Place: Soda Springs, Idaho

18. Funeral Director's **OWN** Signature Arthur W. Hall
and Address Pocatello, Idaho

19. (a) 12-17-1930 (Date received and filed) (b) J. H. Young (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) December 17 19 30
at 5 o'clock a M.

21. **I HEREBY CERTIFY,** That I attended deceased from 12-12 19 30 to 12-17 19 30
I last saw him alive on 12-17 19 30; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death:	Duration
Cerebral Hemorrhage	4 ds.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Where was disease contracted?
Name of operation Date
Major finding
Finding of autopsy

PHYISCIAN Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES,** also fill in the following: Accident? Suicide? Homicide?
Occurred 19 City, county, state where violence occurred
Place of Violence: Home Farm Industry
Public Place While at work?
Means of injury

23. Attendant's **OWN** Signature E. N. Roberts, M.D.
(M. D. or other)
and Address Pocatello, Ida. Date 12-17 19 30
(For additional space, use reverse side)

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED JAN 21 1965 Bureau of Vital Statistics

State of California
County of INYO } ss.

Certificate No. 72976

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Marcus Frederick Whitman (Name on Original Certificate) who died (Was Born or Died) on Dec 17, 1930 (Date of Event)
in Pocatello, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#13 Birthplace of Mother	Maine	Duxbury, Mass.

Subscribed and sworn to before me this 18th day of January, 19 65

Alex. C. Krater

Notary Public, residing at Independence, Calif.

My commission expires Nov. 23, 1965

(Seal)

Signed Marcus F Whitman
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

223 N CLAY INDEPENDENCE CALIF
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of
County of } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this day of , 19

Notary Public, residing at

My commission expires
(Seal)

Signed
(Signature of Any Credible Person)

(Street Address, City, State)

FORM DH 60-155

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72976

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2101 Local Registrar's No. 5965
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10

2. FULL NAME Morgus Frederick Whiteman 74a
(a) Residence. No. Salt Lake City Utah St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Martha Jane Whiteman

6. DATE OF BIRTH (month, day and year) Aug. 2. 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72.	4	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mining Promoter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bono Illinois

PARENTS
10. NAME OF FATHER Edwine C. Whiteman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mass.
12. MAIDEN NAME OF MOTHER Florence H. Swyson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Maine

14. Informant (Address) E. L. Whitman Soda Springs Idaho

15. Filed 12-17, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 17, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-12 30, to 12-17, 1930
that I last saw him alive on 12-17, 1930
and that death occurred, on the date stated above, at 5A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.
12-17, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Soda Springs Ida — Date of Burial: 12-19 1930
20. Undertaker: Arthur W. Hall — Address: Poca Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72977

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5-966

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 956 North Garfield Ave)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME John Freeman
(a) Residence. No. 956 North Garfield St.
(Usual place of abode)
Length of residence in city or town where death occurred. 92 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug. 30. 1870
7. AGE 60 Years 3 Months 7 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railroad Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O.S.L.R.R. Co
9. BIRTHPLACE (city or town) (State or country) Omaha, Nebraska

PARENTS
10. NAME OF FATHER Joseph Freeman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Martha Aspman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs John Freeman
(Address) Pocatello Idaho
15. Filed 1/18 1931 J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 17 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from 12-5, 1930, to 12-17, 1930
that I last saw h[illegible] alive on 12-13, 1930
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:
Coronary Thrombosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. mos. 8 ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
12/18, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View — Date of Burial Dec 19 1930
20. Undertaker Schumacher & Beasley Inc — Address Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72978

PLACE OF DEATH
County of McCammon
City of Bannock

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5967
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maren Chandler Romriell

RECEIVED JAN 10 1931

(a) Residence. No. McCammon, Idaho. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed Married Again.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of A. Romriell

6. DATE OF BIRTH (month, day and year) June 12, 1856

7. AGE Years 74 Months 6 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Erik Eriksen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) Ida Romriell McCammon, Ida.

15. Filed 12/30, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 133

16. DATE OF DEATH December (Month) 19, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-24-, 1930, to Dec-19-, 1930.
that I last saw her alive on Nov-30-, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cholelithiasis with complete obstruction of common duct and Cholemia.
..... (duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. J. Hartvigsen, M. D.
12-27-, 1930. (Address) Downey, Idaho.

19. Place of Burial, Cremation, or Removal Mountain View Cemetery Pocatello, Idaho. Date of Burial 12/22/30 19

20. Undertaker Arthur W. Hall Address Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72979

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216 Local Registrar's No. 5968
(No. 352 West Carson St.)
(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 10 193?

2. FULL NAME Peter Johnson

(a) Residence. No. 352 West Carson St. 131
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hannabell Waring

6. DATE OF BIRTH (month, day and year) Oct, 24, 1878

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	1	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Mrs. Peter Johnson
(Address) 352 West Carson Pocatello Idaho

15. Filed 12/22/30, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug, 1928, to Dec 20, 1930
that I last saw h[illegible] alive on Dec 19, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Uremia
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical

(Signed) J. H. Young M. D.
12/22, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Idaho	12/23/30 19

20. Undertaker Arthur W. Hall
Address Pocatello Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72980

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5969
(No. 269 Washington Ave.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Fred M. Abbott

(a) Residence. No. 269 Washington St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lowell, Mass.

PARENTS

10. NAME OF FATHER Thomas Abbott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont
12. MAIDEN NAME OF MOTHER Ann M. Chadwick
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Vermont

14. Informant E. B. Abbott
(Address) Pocatello, Ida,

15. Filed 12/26/30, 19.... J. H. Young. Registrar.

MEDICAL CERTIFICATE OF DEATH 8813

16. DATE OF DEATH December (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
....., 19..... (Address) Coroner

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello Idaho	12/29/30 19
20. Undertaker	Address
Arthur W. Hall Mortuary	Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7298

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5970
(No.) RECEIVED JAN 10 1931
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Walter ~~Carroll~~ Elmer Chubbuck
(a) Residence. No. General Hospital Pocatello Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. ~~Single~~, Married, ~~Widowed~~, ~~or Divorced (write the word)~~

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Della L Chubbuck

6. DATE OF BIRTH (month, day and year) July 21, 1861

7. AGE Years 69 Months 5 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railroad Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) Passenger Service
(c) Name of employer Oregon Shortline Railroad

9. BIRTHPLACE (city or town) (State or country) Niagara Falls New York

PARENTS
10. NAME OF FATHER A. B. R. Chubbuck
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York State
12. MAIDEN NAME OF MOTHER Laura ← Real last name not known by me. Ingalls
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Raised by Ingalls Family in Niagra Falls NY

14. Informant (Address) Walter Carroll Chubbuck Eden, Idaho

15. Filed 12/27, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 88B

16. DATE OF DEATH 12 (Month) - 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-25, 1930, to 12-26, 1930
that I last saw him alive on 12-26, 1930
and that death occurred, on the date stated above, at 9 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis
(acute)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 8 ds.

18. Where was disease contracted if not at place of death? Blackfoot
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical findings
(Signed) [signature] M. D.
12/26, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal Lone City Cemetery
Date of Burial 12-29 1930

20. Undertaker E. T. Peck
Address Blackfoot

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12982

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 21 Local Registrar's No. 5921
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Teddy Newsom

(a) Residence. No. ~~1022~~ 1022 No 9 ave — St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	15		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work no —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Ernest Newsom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Rosie Jones
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant (Address) J.S. Boynham Pocatello Idaho

15. Filed 1/27, 1931 Registrar

MEDICAL CERTIFICATE OF DEATH 1002

16. DATE OF DEATH 12 (Month) 27 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-24, 1930 to 12-26, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? — Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) T. O. Miller, M. D.
1/27, 1930 (Address) Pocatello Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Morland - Ida	1/28 1930

20. Undertaker E. J. Peck Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Dr Young.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72983

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5962

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Joe Campanella
(a) Residence No. North of Tyhee St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Child
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): March 14-1929
7. AGE: Years 1 | Months 9 | Days — | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Pocatello
PARENTS
10. NAME OF FATHER: Jonea Campanella
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Italy
12. MAIDEN NAME OF MOTHER: Perella
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy
14. Informant: Jonea Campanella
(Address): Tyhee
15. Filed 1/14, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

10

16. DATE OF DEATH: 12 (Month) 14th (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 12/13, 1930, to 12-14, 1930
that I last saw h-m alive on 12-14, 1930
and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:
Nasal Diphtheria
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Tyhee
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory
(Signed) J. H. Young, M. D.
1/14, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mt View — Date of Burial: 12-14th 1930
20. Undertaker: Schumacher & Beasley Inc — Address: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72984

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5961
(No. St. Anthony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Emilio Fonseca

(a) Residence. No. 655 N. 5th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Mexican	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1885

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer) R. R.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mrs. F. D. Paredes

15. Filed 1/16, 1931. J. H. Young Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH Dec (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 30, to Dec. 14, 30
that I last saw him alive on Dec 13, 30
and that death occurred, on the date stated above, at 6a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma Lung, rt.
(duration) yrs. few mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. few ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes No Date of 12/6/30
Was there an autopsy?
What test confirmed diagnosis? Clinical X Ray Opt.
(Signed) H. J. Howard, M. D.
Dec. 15, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cemetery	12/15/30 19
20. Undertaker	Address
H. L. McFarland	Poca. Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72985

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5-960
(No. Pocatello House, Hotel.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. **FULL NAME** Henry Nieman

(a) Residence. No. Pocatello House, East Center St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	75			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Mr. Pete Hansen, Cigar Store East Center St Pocatello

15. Filed 12/17/30, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH 68a

16. DATE OF DEATH December, 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 12, 1930, to Dec 12, 1930
that I last saw h~~im~~ alive on Dec. 12, 1930
12-13-30
and that death occurred, on the ~~date~~ stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 1 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) F. D. Miller, M. D.
12/17, 1930 (Address) Pocatello Ida.

19. Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial: 12/17/30 19

20. Undertaker: Arthur W. Hall — Address: Pocatello Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

V

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12986

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216 Local Registrar's No. 5959
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Benjamin Robert La Rue

(a) Residence. No. 664 N. Fourth St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Colored	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) Pocatello
(State or country) Idaho

PARENTS

10. NAME OF FATHER Robert LaRue
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Louisiana
12. MAIDEN NAME OF MOTHER Elizabeth Bailey
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Louisiana

14. Informant Mrs Robert LaRue
(Address)

15. Filed 12/15, 1930 J. P. Young Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH Dec. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 30, to Dec 13, 30
that I last saw h[illegible] alive on Dec 12, 1930
and that death occurred, on the date stated above, at 8 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) W. W. Brothers M. D.
12-14, 1930 (Address) Pocatello Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View Cemetery	Dec. 13 1930
20. Undertaker	Address
H. L. McHan	Poca. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72989

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 216
Local Registrar's No. 5956
(No.) St. Anthony Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Bernard Curran

(a) Residence. No. 133 S. Garfield St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 27-1867

7. AGE: Years 63 | Months 1 | Days 12 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Gang Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): O.S.L. R.R.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10. NAME OF FATHER: Edward Curran
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs H Daly
(Address): Pocatello Idaho

15. Filed 12/14, 1930 — J. H. Young, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12, 1930, to Dec 9, 1930
that I last saw him alive on Dec 9, 1930
and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:
Encephalitis lethargica
(duration) yrs. mos. 29 ds.

CONTRIBUTORY (Secondary) ?
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Pathologic findings

(Signed) A. M. Newton M. D.
Dec 10, 1930 (Address) 202 Carson Bldg Pocatello Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Mountain View — Date of Burial: Dec 12 1930
20. Undertaker: Schumacher & Bradley — Address: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72990

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 216
(No. Tyhee Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5955

RECEIVED JAN 10 1931

2. FULL NAME Ralph Valenty
(a) Residence. No. R.R. 1 Pocatello St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) July 9th 1926

7. AGE Years 4 Months 4 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Springfield Idaho

PARENTS
10. NAME OF FATHER Sam Valenty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Assunta Sanelli
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Italy

14. Informant Sam Valenty
(Address) R.R. 1 Pocatello Idaho

15. Filed 12/8, 1930 J. Young Registrar

MEDICAL CERTIFICATE OF DEATH 1010

16. DATE OF DEATH Dec 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/3, 1930, to 12/8, 1930
that I last saw him alive on 12/8, 1930
and that death occurred, on the date stated above, at 5.35 A m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Tyhee
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. Young M. D.
12/8, 1930 (Address) Pocatello

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View Date of Burial Dec 14 1930

20. Undertaker Schumacher & Beasley Inc Address City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72991

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2101 Local Registrar's No. 5954
(No. Oliver Hotel, Pocatello Idaho)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME J.M. Duffey
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE: Unknown — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Doctor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Arthur W. Hall (Cornor)

15. Filed 12/12/1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 92

16. DATE OF DEATH December, 7, 1930, 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1930 to Dec 7, 1930
that I last saw him alive on Dec 7, 1930
and that death occurred, on the date stated above, at 6.30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Embolism of right lung
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dope & Liquor
..... (duration) 20 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? yes
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam
(Signed) [signature], M. D.
12/11/30, 19..... (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Pocatello Idaho — Date of Burial 19

20. Undertaker: Arthur W. Hall Mortuary — Address: Poca., Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72902

PLACE OF DEATH
County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2164
Local Registrar's No. 5953
(No. Pocatello Idaho.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Allen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

RECEIVED JAN 10 '31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
Unknown				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Arthur W. Hall (Cornor)
(Address) Pocatello Idaho

15. Filed 12/12/30, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH 68B

16. DATE OF DEATH December (Month), 6 (Day), 1930 (Year), 19....

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....
(Signed) Arthur W. Hall, (Cornor) M. D.
12/12, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Pocatello, Idaho	19
20. Undertaker	Address
Arthur W.Hall	Poca., Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12993

PLACE OF DEATH
County of Bannock
City of Pocatello

Registration District No. 28
Primary Registration District No. 2101 Local Registrar's No. 5952
(No. Pocatello General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

JAN 10 1931

2. FULL NAME Lewanda Brown
(a) Residence. No. Hotel Temple N. Main ST. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): Cafes.
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Oregon

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address): Dr. J. J. Roof "assigned"
15. Filed 12/6, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 5. 1930 (Month) (Day) 165 (Year) 19
17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 5, 1930
that I last saw her alive on Dec 4, 1930
and that death occurred, on the date stated above, at 3 25 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bichloride of mercury poisoning. Taken with suicidal intent.
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? Temple Hotel
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John J. Roof, M. D.
Dec 6, 1930 (Address) Pocatello Idaho

19. Place of Burial, Cremation, or Removal | Date of Burial 19
20. Undertaker: H. L. McHan | Address: Poca. Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72994

PLACE OF DEATH

County of Bannock
City of Pocatello
Registration District No. 28
Primary Registration District No. 2101 Local Registrar's No. 5957
(No. Pocatello, General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maybelle A. Dillon

(a) Residence. No. 755 West Sublett St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. Dillon

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Tobenach
(State or country) Nebraska

PARENTS

10. NAME OF FATHER Chas. P. Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER LeLean Wheaton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Conn.

14. Informant Mr. Wm Dillon
(Address)

15. Filed 1/6, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH Dec. (Month) 5. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 30, to Dec 6, 1930
that I last saw alive on Dec 5, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of lung
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Pneumonia rt Lung
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date Nov
Was there an autopsy? Yes
What test confirmed diagnosis? Pathologist
(Signed) W. W. Brothers, M. D.
12-6, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. View. Cemetery	11/7/30 19
20. Undertaker	Address
K. L. McKean	Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72995

PLACE OF DEATH
County of Bannock
City of Pocatello,

Registration District No. 28
Primary Registration District No. 2161 Local Registrar's No. 5950
(No. 1324 N. Hayes)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 10 1931

2. FULL NAME Anna Katherine Elsen
(a) Residence. No. 1324 N. Hayes St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 30 yrs. 7 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Theo Elsen
6. DATE OF BIRTH (month, day and year): April 16, 1860
7. AGE: Years 70, Months 7, Days 5. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Houskeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Unknown

14. Informant (Address): Mr. Theo. Elsen
15. Filed 12/6, 1930. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH: Dec. 4, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 22, 1930, to Dec 4, 1930
that I last saw her alive on Dec 3, 1930
and that death occurred, on the date stated above, at 6 a. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
12/5, 1930 (Address) Pocatello

19. Place of Burial, Cremation, or Removal: Mt. View Cemetery
Date of Burial: 19
20. Undertaker: H. L. McHan
Address: Poca

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72996

Registration District No. 28
Primary Registration District No. 2161
Local Registrar's No. 5949

PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Estoria Ranch)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Edward Estoria

RECEIVED JAN 16 1931

(a) Residence. No. East of City St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 30th 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	5	2	X

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Milwaukee Wis

PARENTS

10. NAME OF FATHER Estoria

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Nellie O Flanders

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs C E Estoria
(Address) Pocatello Ida

15. Filed 1/3, 1931. Registrar

MEDICAL CERTIFICATE OF DEATH 68a

16. DATE OF DEATH 12 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23, 1930, to Dec 2, 1930
that I last saw him alive on Dec 1, 1930
and that death occurred, on the date stated above, at 2 P m.
The CAUSE OF DEATH* was as follows:
Cardiac dilatation

(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) F. O. Miller, M. D.
1/3, 1930 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt View	12-7 1930
20. Undertaker	Address
Schumacher & Beasley	Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12997

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 53
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 157

2. FULL NAME Harold Ellis Law

(a) Residence. No. Paris Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Aug 18, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Charles J Law
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho
12. MAIDEN NAME OF MOTHER Edna Ellis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho

14. Informant X Rhus J Law
(Address) Paris Idaho

15. Filed Dec 2, 1930 Mrs. J. B. Skinner, Registrar
Per Dr. C. O. Moore

MEDICAL CERTIFICATE OF DEATH 99a

16. DATE OF DEATH Dec (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1930, to Dec 1, 1930
that I last saw him alive on Dec 1, 1930
and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:
Acute Bronchites, Bilateral
Myocarditis Acute
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Myocarditis Acute
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore, M. D.
12/1/30, 19 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~	Date of Burial
Paris, Idaho.	Dec. 3rd 1930
20. Undertaker	Address
Edwin & Shepherd	Paris, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A ...

N. B.—Every item of information should be carefully supplied. AGE should be stated ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72998

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. ...
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. ...

RECEIVED JAN 8 1931

2. FULL NAME Alfred F Anderson
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan 30 - 1866
7. AGE Years 64 Months 9 Days 8 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS
10. NAME OF FATHER Andrew F Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Anna Okerberry
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Clarence Anderson
(Address) Montpelier Idaho
15. Filed 12/31, 1930 N N Kerr Registrar

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH Nov (Month) 8 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 8, 1930, to Nov 8, 1930
that I last saw ~~h~~ alive on Nov 8, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) age
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? none
What test confirmed diagnosis?
(Signed) W F Lesley, M. D.
11-9-, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Grantsville Utah Date of Burial Nov 12 1930
20. Undertaker H. Williams Address Montpelier Idaho

STATE OF IDA...
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 72999

PLACE OF DEATH
County of Bear Lake
City of Pegram

Registration District No. 52
Primary Registration District No. 136
(No. ...
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. ...

JAN 8 1931

2. FULL NAME Kenneth Londos Baker

(a) Residence. No. Pegram St. 205-B
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years | Months | Days 10 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pegram

PARENTS
10 NAME OF FATHER Londos O. Baker
11 BIRTHPLACE OF FATHER (city or town) (State or country) Missouri
12 MAIDEN NAME OF MOTHER Katie Williams
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montpelier, Ida.

14 Informant Londos O. Baker
(Address) Pegram Idaho

15 Filed 12/31, 1930 N. N. Ling Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 (Month) 3 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 9-24, 1930, to 10-1, 1930, that I last saw h... alive on 10-1, 1930, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:
Unknown
New born infant
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Gaertner M. D.
10-3, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal Pegram Idaho
Date of Burial 10/31 1930

20. Undertaker F. M. Williams
Address Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13060

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 2
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 8 1931

2. FULL NAME Gladys V. Peterson
(a) Residence. No. International Falls St. Minnesota
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rupert Ed Peterson

6. DATE OF BIRTH (month, day and year) Sept 25, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25		3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10. NAME OF FATHER Wm. H. Eddy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden
12. MAIDEN NAME OF MOTHER Emelie Benson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Rupert Ed Peterson
(Address) International Falls, Minn

15. Filed 12/3/, 1930 N. H. Rees Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH Oct 1st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1930 to Oct 1, 1930
that I last saw h alive on Oct 1, 1930
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary T.B.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? What test confirmed diagnosis?
(Signed) J. H. Rees M. D.
Oct 1, 1930 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
International Falls	Oct 4, 1930

20. Undertaker H. H. Williams
Address Montpelier, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS; if less than one year, state MONTHS or DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7300

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 6 '31

2. **FULL NAME** John W. Gardner

(a) Residence. No. Montpelier Idaho St. 185
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1 1912

7. AGE Years	Months	Days	If LESS than 1 day,
18	5	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farm Hand
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS
10. NAME OF FATHER E. P. Gardner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Fish Haven Idaho
12. MAIDEN NAME OF MOTHER Ethel L. Shupe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montpelier Idaho

14. Informant E. P. Gardner
(Address) Montpelier Idaho

15. Filed 12/31, 1930 M. Peters Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 9, 1930
that I last saw h alive on Sept 9, 1930
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:
Fracture Base of Skull
(Fell from a horse)
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Rodeo accident
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept 8-1930
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. P. Gardner M. D.
9-10, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montpelier Idaho	Sept 12 1930

20. Undertaker Address
Montpelier Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73002

Registration District No. 5-2
Primary Registration District No. 7136
Local Registrar's No.

PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Louis J Stuart
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): July 18 ~~1880~~ 1930
7. AGE: Years 50 | Months 2 | Days 8 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Rail Road Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Oregon Short Line Ry Co
9. BIRTHPLACE (city or town) (State or country): Wardboro Idaho

PARENTS
10. NAME OF FATHER: David C Stuart
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Alabama.
12. MAIDEN NAME OF MOTHER: Mary Lucas.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Mrs Louis J Stuart
(Address) Montpelier Idaho
15. Filed 1/7/31, 1930 N. V. Avery Registrar

MEDICAL CERTIFICATE OF DEATH 8813

16. DATE OF DEATH: Sept (Month) 26 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 1, 1930, to Sept 26, 1930
that I last saw h~~i~~m alive on Sept 26, 1930
and that death occurred, on the date stated above, at 8:11 P. m.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart Block
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. P. Gardner, M. D.
Sept 27, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Montpelier Idaho — Date of Burial: Sept 29 1930
20. Undertaker: J. W. Williams — Address: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73023

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 5-2
Primary Registration District No. 2136
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Doris Arlene Anderson.
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 23. 1922.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montpelier Idaho

PARENTS
10. NAME OF FATHER Carl G Anderson.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden.
12. MAIDEN NAME OF MOTHER Lillian Gregory.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Montpelier Idaho

14. Informant Carl G Anderson
(Address) Montpelier Idaho

15. Filed 12/31, 1930 H. H. Keen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 90
(Month) Aug (Day) 29 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1930, to Aug 29, 1930
that I last saw h-r alive on Aug 29, 1930
and that death occurred, on the date stated above, at 12:10P m.
The CAUSE OF DEATH* was as follows: Acute Dilatation of Heart

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Mitral Stenosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? H. H. Keen
What test confirmed diagnosis?
(Signed) H. H. Keen, M. D.
Aug 29, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montpelier Idaho	Aug 31 1930

20. Undertaker	Address
J. A. Williams	Montpelier Ida

IMPORTANT.—Every item of information should be carefully supplied. Read carefully, paying particular attention to the items which should be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73004

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 54
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. .....

RECEIVED JAN 8 1931
205 B

2. FULL NAME Carl Wuthrich
(a) Residence. No. Montpelier Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20 - 1914

7. AGE Years 26 Months 7 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk. (Butcher)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Montpelier
(State or country) Idaho

PARENTS
10. NAME OF FATHER Samuel Wuthrich
11. BIRTHPLACE OF FATHER (city or town) Switzerland
(State or Country)
12. MAIDEN NAME OF MOTHER Elizabeth Groesjean
13. BIRTHPLACE OF MOTHER (city or town) Switzerland
(State or Country)

14. Informant Edward Wuthrich
(Address) Montpelier Idaho

15. Filed 12/31, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13, 1930, to Aug 20, 1930
that I last saw him alive on Aug 20, 1930
and that death occurred, on the date stated above, at 10:15 P m.
The CAUSE OF DEATH* was as follows: Unknown
No diagnosis
(Fever + headache)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) G. P. Gaertner M. D.
Aug 21, 1930 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial Aug 24 1930

20. Undertaker [signature] Address Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73066

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 5
Primary Registration District No. 2136
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 8 1931
117

2. FULL NAME Margaret Marie Agerter
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 20 - 1912

7. AGE Years 17 Months 18 Days 22 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan Utah.

PARENTS
10. NAME OF FATHER J Fred Agerter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland.
12. MAIDEN NAME OF MOTHER Marie Kohler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant J Fred Agerter
(Address) Montpelier Idaho

15. Filed 12/31, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7, 1930, to Aug 11, 1930
that I last saw her alive on Aug 11, 1930
and that death occurred, on the date stated above, at 7.55 P m.
The CAUSE OF DEATH* was as follows:
Pus - Appendicitis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Operation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 7-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
Aug 12, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial Aug. 14 1930

20. Undertaker [signature]
Address Montpelier Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7306

Registration District No. 5
Primary Registration District No. 2126
Local Registrar's No.

PLACE OF DEATH
County of Bear Lake
City of Montpelier (No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Minnie M. Lowery
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos. Lowery

6. DATE OF BIRTH (month, day and year): Jan 30 1849.

7. AGE: 81 Years | 6 Months | 26. Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Perth Ontario Canada

PARENTS
10. NAME OF FATHER: Andrew Allen.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Balderson Ontario Canada.
12. MAIDEN NAME OF MOTHER: Jane Patterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Canada

14. Informant: Mrs. Chas. Hancock
(Address) Montpelier Idaho

15. Filed 1/7/31, 1930 J. H. Lee Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH: Aug (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1930, to Aug 25, 1930
that I last saw her alive on Aug 24, 1930
and that death occurred, on the date stated above, at 9:15 A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? H. H. Lee
What test confirmed diagnosis?
(Signed) H. H. Lee, M. D.
Aug 26, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Montpelier Idaho	Aug 27 - 1930
20. Undertaker	Address
H. H. Williams	Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73008

PLACE OF DEATH
County of Bear Lake
City of Georgetown

Registration District No. 52
Primary Registration District No. 2136

Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Lucy Vilate Bruce

(a) Residence. No. Georgetown Idaho St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 3-1930

7. AGE Years 15 Months 3 Days 6. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Thos Bruce.
(b) General nature of industry, business, or establishment in which employed (or employer) At School.
(c) Name of employer

9. BIRTHPLACE (city or town) Montpelier Idaho
(State or country)

PARENTS

10. NAME OF FATHER Thos Bruce
11. BIRTHPLACE OF FATHER (city or town) Ogden Utah.
(State or Country)
12. MAIDEN NAME OF MOTHER Emma Smith
13. BIRTHPLACE OF MOTHER (city or town) Kemington Utah
(State or Country)

14. Informant Thos Bruce
(Address) Georgetown Idaho

15. Filed 1/31, 1930 H. H. King Registrar

MEDICAL CERTIFICATE OF DEATH 24

16. DATE OF DEATH Aug 3 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to Aug 3, 1930
that I last saw her alive on Aug 2, 1930
and that death occurred, on the date stated above, at 2 a. m.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis (Epidemic)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Russell Tigert, M. D.
Aug 4, 1930 (Address) Soda Springs

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho
Date of Burial Aug 3 - 1930

20. Undertaker [illegible] Williams
Address Montpelier Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73003

PLACE OF DEATH
County of Bear Lake
City of Georgetown
Registration District No. 57
Primary Registration District No. 2736
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 '30

2. FULL NAME Grover Payne
(a) Residence. No. Georgetown Idaho St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 4 1917

7. AGE	Years	Months	Days	If LESS than 1 day,
	12	9	26	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bloomington Idaho

PARENTS
10. NAME OF FATHER Ezekiel Payne
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bloomington Idaho
12. MAIDEN NAME OF MOTHER Ada Smart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lyndale Utah

14. Informant Ezekiel Payne
(Address) Georgetown Idaho

15. Filed Jan 31, 1930 N. Nunn Registrar

MEDICAL CERTIFICATE OF DEATH 1880

16. DATE OF DEATH July (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930 to July 30, 1930
that I last saw him alive on July 30, 1930
and that death occurred, on the date stated above, at 1:15 P m.
The CAUSE OF DEATH* was as follows:
Drowned in Bear River
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fractured Skull
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Lee F Eckley, M. D.
July 31, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Georgetown Idaho	Aug 1 1930

20. Undertaker J. H. McWilliams Address Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73010

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

89

RECEIVED JAN 8 1931

2. FULL NAME Henry D. Kunz
(a) Residence. No. Bern Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) May 30-1886
7. AGE Years 44 Months 2 Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Bern Idaho.

PARENTS
10. NAME OF FATHER Christian Kunz.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Eliza Buhler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Mrs Henry D. Kunz
(Address) Bern Idaho
15. Filed 1/31, 1930 H. H. Kunz Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 30, 1930, to July 30, 1930
that I last saw him alive on July 30, 1930
and that death occurred, on the date stated above, at 1:25 P. m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) H. H. Kunz, M. D.
Aug 1, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Bern Idaho
Date of Burial Aug 3. 1930
20. Undertaker J. H. Williams
Address Montpelier, Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73011

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 3136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

RECEIVED JAN 8 1931

2. FULL NAME Joseph Bagley
(a) Residence. No. Montpelier Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec-25-1865

7. AGE 64 Years | Months 6 | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railroad Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 yrs
(c) Name of employer Oregon Short Line Ry

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER George Bagley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Sarah Severn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Jos Bagley
(Address) Montpelier Idaho

15. Filed 12/31/1930 N. H. King Registrar

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH July (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 22, 1930
that I last saw him alive on July 20, 1930
and that death occurred, on the date stated above, at 8.55 p m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J. P. Galstines M. D.
July 23, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho | Date of Burial July 25 1930

20. Undertaker J. M. Williams | Address Montpelier Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13012

Local Registrar's No.

PLACE OF DEATH
County of Bear Lake
City of Montpelier
Registration District No. 5-7
Primary Registration District No. 736
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Frank Sunderland.

(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 1 - 1860

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	5	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Stockman
(b) General nature of industry, business, or establishment in which employed (or employer) Baker.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt Vernon Ohio

PARENTS

10. NAME OF FATHER Richard Sunderland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Mary Rose
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs Frank Sunderland
(Address) Montpelier Idaho

15. Filed 1/31/, 1931 N. N. Kemp Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1930, to July 18 1930
that I last saw h. alive on July 18, 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Auricular Heart Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) N. N. Kemp, M. D.
July 19, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Date of Burial
Montpelier Idaho July 22 1930

20. Undertaker — Address
J. H. Williams Montpelier Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73013

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. .....

RECEIVED JAN 8 1931

2. FULL NAME John A. Skinner
(a) Residence. No. Norman, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 11-1856

7. AGE Years 73 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Atlantic Ocean

PARENTS
10. NAME OF FATHER John Skinner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Naplis Skinner
(Address) Norman Idaho

15. Filed 12/31/1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH July (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 13, 1930
that I last saw him alive on July 13, 1930
and that death occurred, on the date stated above, at 8:45 P m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis .....
(Signed) G. P. Gaertner M. D.
July 14, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Norman Idaho
Date of Burial July 15 1930

20. Undertaker [illegible] Williams
Address Montpelier Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73014

PLACE OF DEATH
County of Bear Lake
City of Georgetown

Registration District No. 52
Primary Registration District No. 2136
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

RECEIVED JAN 6 1930

2. FULL NAME Emily Rolph
(a) Residence. No. Georgetown Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 19 - 1847

7. AGE Years: 83 Months: — Days: 1 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER Joseph Patterell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Albert Bacon
(Address) Georgetown Idaho

15. Filed 12/3/, 1930 N. Noting Registrar

MEDICAL CERTIFICATE OF DEATH 164

16. DATE OF DEATH ~~October~~ 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows: — Unknown
Senile Debility
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Old age
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Ellis Hackley, M. D.
Oct 21, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Georgetown Idaho
Date of Burial: Oct 21 1930

20. Undertaker: [illegible] Williams
Address: Montpelier Idaho

...TION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73015

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2131
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 8 1931

2. FULL NAME Donald W Stephens
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 1 - 1930

7. AGE Years Months 3 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montpelier Idaho

PARENTS
10. NAME OF FATHER Myrl Stephens
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Bennington Idaho
12. MAIDEN NAME OF MOTHER Freda Gortcinsky
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mammoth Utah

14. Informant Myrl Stephens
(Address) Montpelier Idaho

15. Filed 12/31, 1930 H H Kerry Registrar

MEDICAL CERTIFICATE OF DEATH 1010

16. DATE OF DEATH Nov (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930, to Nov 2, 1930
that I last saw him alive on Nov 1, 1930
and that death occurred, on the date stated above, at 4.30 a. m.
The CAUSE OF DEATH* was as follows: Pneumonia, Lobar LLL
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) C O Moore, M. D.
Nov 2, 1930 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Montpelier Idaho | Date of Burial Nov 3 1930

20. Undertaker J M Williams | Address Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73016

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Anna Applegger Jonely
(a) Residence. No. Montpelier Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Jonely
6. DATE OF BIRTH (month, day and year) Mar 12-1873.
7. AGE Years 57 Months 6 Days 23 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) ? Applegger Switzerland

PARENTS
10. NAME OF FATHER P. Applegger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Switzerland

14. Informant Wm Jonely
(Address) Montpelier Idaho
15. Filed 12/31, 1930 N N King Registrar

MEDICAL CERTIFICATE OF DEATH 89

16. DATE OF DEATH Nov (Month) 5 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 5, 1930, to Nov 5, 1930
that I last saw h— alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) N N King, M. D.
Nov 5, 1930 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Date of Burial
Montpelier Idaho Nov. 9 1930
20. Undertaker Address
F. M. Williams Montpelier Idaho

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. EXA...
...TION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73017

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 436
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Violet C. Clark
(a) Residence. No. Georgetown Ida St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Clark

6. DATE OF BIRTH (month, day and year) March 12 1893

7. AGE 37 Years | Months 8 | Days 2 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Arizona

PARENTS
10. NAME OF FATHER Jos M. Christensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Emma Christansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Walter Clark
(Address) Georgetown Idaho

15. Filed 12/31, 1930 N. N. Kerry Registrar

MEDICAL CERTIFICATE OF DEATH 47

16. DATE OF DEATH Nov (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Nov 14, 1930
that I last saw her alive on Nov 14, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Breast
(duration) ..... yrs. 8 mos. 1 ds.
CONTRIBUTORY (Secondary) Metastasis of lives
(duration) ..... yrs. 3 mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J. P. Gaertner M. D.
Nov 15, 1930 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Georgetown Idaho | Date of Burial Nov. 18 1930

20. Undertaker D. M. Williams | Address Montpelier Idaho

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Ex...
...TION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73018

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 57
Primary Registration District No. 21 37
Local Registrar's No.

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Niels Overgaard.

(a) Residence. No. Montpelier Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 23 - 1857

7. AGE: Years 73 | Months 2 | Days 21 | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark.

PARENTS

10. NAME OF FATHER: Niels Overgaard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Laura Jensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Esper Overgaard.
(Address): Box 8 Bear Lake

15. Filed 1/3/31, 1930 N. N. Kerr Registrar

MEDICAL CERTIFICATE OF DEATH 10.1a

16. DATE OF DEATH: Dec (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 15, 1930
that I last saw h~~is~~ alive on Dec 15, 1930
and that death occurred, on the date stated above, at 12-40 P m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. P. Jackson M. D.
Dec 16, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Evid Idaho	Dec 19 1930
20. Undertaker	Address
J. H. Williams	Montpelier Idaho

SHOW JUST CAUSE OF DEATH in plain terms, so that it may be properly classified. ATTENTION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73019

PLACE OF DEATH
County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 436
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

RECEIVED JAN 9 '31

2. FULL NAME Ingeborg H. Overgaard
(a) Residence. No. Montpelier Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 19 - 1930

7. AGE Years 67 Months 1 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Norway

PARENTS
10. NAME OF FATHER Jno Hansen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Ingeborg Hoyansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway

14. Informant Emil Overgaard
(Address) Boise Idaho

15. Filed 12/31/, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH Dec (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1930, to Dec 19, 1930
that I last saw her alive on Dec 19, 1930
and that death occurred, on the date stated above, at 5 A m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) J. P. Gaertner M. D.
Dec 20, 1930 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Ovid Idaho
Date of Burial Dec. 21. 1930

20. Undertaker [signature] Address Montpelier

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ...TION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73020

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bingham
City of Springfield

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 182
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lewis Florence

(a) Residence. No. St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 17, 1930

7. AGE Years Months 3 Days 25 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City, Utah

PARENTS
10. NAME OF FATHER Wilmer Florence
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Utah
12. MAIDEN NAME OF MOTHER Mabel Wilkinson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) J. Lewis Wilkinson 603 Bryan Ave, Salt Lake City Ut.

15. Filed Dec 13, 1930 Mon Walter E. Petrie Registrar.

MEDICAL CERTIFICATE OF DEATH 100a

16. DATE OF DEATH Dec 12, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceas~~ investigated from death, 19, to, 19
that I last saw h alive on, 19
and that death occurred, on the date stated above, at 6:45 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia - Bronchial
Indigestion from artificial feeding.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Indigestion
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? Salt Lake City Ut.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History of case
(Signed) W. E. Petrie, M. D.
Dec 13, 1930 (Address) Blackfoot

19. Place of Burial, Cremation, or Removal Salt Lake City Ut. Date of Burial, On arrival

20. Undertaker acting. J. L. Wilkinson Address ~~Ida~~ Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73021

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 181

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Norma Rose

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Mch. 31" 1926

7. AGE Years 4 Months 9 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Shelley Ida

PARENTS
10. NAME OF FATHER Wm Rose
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Hyrum Utah
12. MAIDEN NAME OF MOTHER Jennie Hansen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Hyrum Utah

14. Informant
(Address) W. C. Rose Shelley Ida

15. Filed Dec 10, 1930 Mrs Walter E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH Dec (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1930, to Dec 8 1930
that I last saw her alive on Dec 7 1930
and that death occurred, on the date stated above, at 11 39 m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(duration) yrs. mos. (9) ds.
CONTRIBUTORY (Secondary) Acute dilation of heart
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) F. W. Robertson M. D.
Dec 8, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Goshen, Cemetery
Date of Burial Dec 10 - 1930

20. Undertaker Jack A. Wood
Address Idaho Falls Ida

Ft. Hall Jurisdiction

Idaho.

RECEIVED JAN 5 1931

Current Complete

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Aug. 1930

DO NOT WRITE IN THIS SPACE

State File No. 73022

PLACE OF DEATH

County of Bingham

City of Ft. Hall Reser'vn. Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 180

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wilforn Sawyer

(a) Residence. No. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 7/8	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 30, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	3	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pocatello, Idaho.

PARENTS

10. NAME OF FATHER Pat Joe Sawyer

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft. Hall Reservation

12. MAIDEN NAME OF MOTHER Lillian Navo

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft. Hall Reservation

14. Informant Pat Joe Sawyer
(Address) Ft. Hall, Idaho

15. Filed Dec. 30, 1930 Wm Wallace E. Reg. Registrar.

MEDICAL CERTIFICATE OF DEATH 162

16. DATE OF DEATH August 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19....

that I last saw h... alive on ..., 19....

and that death occurred, on the date stated above, at 11:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

Date of Onset 8/14/30

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Mary W. Miller, M. D.

..., 19.... (Address)

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cem. Ft. Hall Resv.	8/18/30 19

20. Undertaker	Address
Pat Joe Sawyer,	Ft. Hall, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Delayed Complete

June 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73023

Ft.Hall Jurisdiction

RE JAN 5 1931

PLACE OF DEATH

County of Bingham

City of Ft.Hall Reser'vn Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 174

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gladys Wahtomy

(a) Residence. No. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. I9, I929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation.

PARENTS

10. NAME OF FATHER Frank Wahtomy

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Alma Bearskin

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant Alma Wahtomy
(Address) Ft.Hall, Idaho.

15. Filed Dec.30, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH 162

16. DATE OF DEATH June 26, I930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19..... to , 19.....
that I last saw h..... alive on , 19.....
and that death occurred, on the date stated above, at 9:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cholera Infantum.

Date of Onset: 6/12/30

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Information

(Signed) Henry R. Wheeler, M. D.

, 19..... (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal: Butte Cem. Ft.Hall Res. Date of Burial: 6/28/30 19

20. Undertaker: Frank Wahtomy, Ft.Hall, Address: Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

Ft. Hall Jurisdiction

Delayed Complete

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

June 1930

DO NOT WRITE IN THIS SPACE

State File No. 73024

RECEIVED JAN 5 19

PLACE OF DEATH

County of Bingham

City of Ft. Hall Reser'n

Registration District No. 12I

Primary Registration District No. 2194

Local Registrar's No. 178

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sallie Ocean

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Bannock Ind. 4/4	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ralph Ocean

6. DATE OF BIRTH (month, day and year) - 1861-

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife & Home-work
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Boise, Idaho

PARENTS

10. NAME OF FATHER Waw-da-cah

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Ba-em-bier

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Bruno, Idaho.

14. Informant (Address) Alex Watson Blackfoot, Idaho.

15. Filed Dec. 30, 1930 W. Walter E. Peters Registrar.

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH June 25, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19..... to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at Noon m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Aprplexy,-cerebral

Date of onset, 6/25/30

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Henry R. Mueller, M. D.

....., 19..... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal: Mt. Putnam Cem. Ft. Hall Res. — Date of Burial: 6/27/30 19

20. Undertaker: Brown & Eldredge, Blackfoot, Ida. — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

Ft.Hall Jurisdiction

Delayed Complete

May 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 13025

REC'D JAN 5 1931

PLACE OF DEATH

County of Bingham

City of Ft.Hall Res.

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 1

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Nagitie

(a) Residence. No. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Yamb Box

6. DATE OF BIRTH (month, day and year) 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lemhi Reservation

PARENTS

10. NAME OF FATHER Kin-da-gah

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Frank Wahtomy
(Address) Ft.Hall, Idaho

15. Filed Dec.30, 1930 Walter E. Peterson
Registrar.

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH May 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
No Doctor attending, 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 11:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

Date of Onset: 12/18/30

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M.D.
....., 19.... (Address) Ft.Hall, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Butte Cem. Ft.Hall Res.	5/21/30 19

20. Undertaker Agency Carpenter, Ft.Hall Res. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Ft.Hall Jurisdiction — Delayed Complete — May 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 13626

PLACE OF DEATH

County of Bingham

City of Ft.Hall Reser'vn Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 16

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Ingaquasha

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind.	Widower

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mayr Nagitsy

6. DATE OF BIRTH (month, day and year) 1840

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	-	-	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Lemhi Reservation

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant George Ingiap
(Address) Ft.Hall, Idaho.

15. Filed Dec. 30, 1930 Walter E. Patrick
Registrar.

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH May 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 7, 1930, that I last saw him alive on May 7, 1930, and that death occurred, on the date stated above, at 3:A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Nephritis- chronic.
Date of Onset May 11, 1927

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

..... (duration) ..... yrs. ..... mos. I ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? NO Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Analysis urine

(Signed) [illegible], M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal: Presbyterian Mission, Ft.Hall, Idaho. Date of Burial: 5/19/30 19

20. Undertaker: Agency Carpenter, Ft.Hall, Ida Address .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73028

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2191
Local Registrar's No. 192
(No. South Idaho Insane Asylum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elisha Holloway

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 26th, 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Joab Holloway ~~Unknown~~

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER ~~Unknown~~ Mary Rooker

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Joseph Moore
(Address) Blackfoot.

15. Filed Dec 25, 1930 Mrs Walter E. Parks
Registrar.

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Dec 25th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12th, 1930 to Dec 25th 1930
that I last saw him alive on Dec 25th, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? O
What test confirmed diagnosis? Clinic
(Signed) Geo Williams, M. D.
Dec 25th, 1930 (Address) Blackfoot

19. Place of Burial, Cremation, or Removal: Groveland Cemetery — Date of Burial: Dec 28 1930

20. Undertaker: G J Funk — Address: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73029

PLACE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 1007
Local Registrar's No. 191
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James H. Kenny

(a) Residence. No. ..... St. Billings Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. ..... mos. 1 ds. ..... How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds. .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	45			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Hide Buyer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Ray McClellan
(Address) Blackfoot, Ida.

15. Filed Dec 26, 1930 Wm Walter E. Pettis
Registrar

MEDICAL CERTIFICATE OF DEATH 127

16. DATE OF DEATH Dec. 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at about 10 30 P. m.
The CAUSE OF DEATH* was as follows:
Acute indigestion
.....(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) C O Humphrey M. D.
Dec 26, 1930 (Address) Blackfoot
Ray McClellan County Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cemetery	12-26-1930
20. Undertaker	Address
Modern Mortuary	Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13030

PLACE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 190
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lial LeRoy Kofoed

(a) Residence. No. Blackfoot. Rt. 5 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Isabel Kidd Kofoed

6. DATE OF BIRTH (month, day and year) July.1. 1906

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	5	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Ida.

PARENTS

10. NAME OF FATHER Oliver Kofoed
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Mabel Byington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Oliver Kofoed
(Address) Blackfoot, Rt. 5

15. Filed Dec 31, 1930 Mrs. Mattie E. Petrie Registrar

MEDICAL CERTIFICATE OF DEATH 88W

16. DATE OF DEATH Dec (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 23, 1930, that I last saw him alive on Dec 23, 1930, and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W W Beck, M. D.
12/31, 1930 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Grove City Cem.	12-26-30 19

20. Undertaker	Address
Modern Mortuary -- Black	foot, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73031

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 1007 Local Registrar's No. 189
(No. 427 No Oak Street Blackfoot Idaho
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henrietta Alcorn

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Alcorn

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 76 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Minnisota

PARENTS

10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Don't Know
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or County): " "

14. Informant (Address): A. S. Bolstad, Blackfoot, Id.

15. Filed Dec 26, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH 74N

16. DATE OF DEATH: Dec 23 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1928, to Dec 23, 1930
that I last saw her alive on Dec 1, 1930
and that death occurred, on the date stated above, at 4:00 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (duration) ..... yrs. ..... mos. 1 hr. ~~ds.~~

CONTRIBUTORY (Secondary): Syphilis
..... (duration) 13 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Don't Know
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physiogn
(Signed) W. E. Patrick, M. D.
Dec 23, 1930 (Address) Blackfoot Idaho

19. Place of Burial, Cremation, or Removal: Rose Hill Cem (Idaho Falls) | Date of Burial: Dec. 24 1930

20. Undertaker: E. J. Peck | Address: Blackfoot

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73032

PLACE OF DEATH
County of Bingham
City of Blacki ot

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 188
(No. South Idaho Insane As lum)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Helen R Hamer

(a) Residence. No. Middleton Idaho St. Caldwell
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 9 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Dr. John W. Hamer

6. DATE OF BIRTH (month, day and year) ~~Dec 22~~ Nov. 30 1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	- -	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Wm A Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penna

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant Minnie Hayes-Att.
(Address) Blackfoot Idaho

15. Filed Dec. 27, 1930 Mrs Walter E. Patrie
Registrar.

MEDICAL CERTIFICATE OF DEATH 96

16. DATE OF DEATH Dec 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12th 1930 to Dec 22, 1930
that I last saw her alive on Dec 22nd, 1930
and that death occurred, on the date stated above, at 10 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

General Paralysis of Insane
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Wasserman

(Signed) Geo. McLean, M. D.
Dec 22nd, 1930 (Address) Blackfoot

19. Place of Burial, Cremation, or Removal	Date of Burial
Middleton Ida Cemetery	12 -27-30
20. Undertaker	**Address**
Paul L. Case	Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73034

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 186

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Flavilla Maud Hardy

(a) Residence. No. East Alice St. Blackfoot, Ida St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov. 14, 1930.

7. AGE: Years 0 | Months 1 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Blackfoot, Ida.

PARENTS

10. NAME OF FATHER: E. L. Hardy

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Savilla Patton

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Idaho.

14. Informant: W. W. Patten
(Address) Blackfoot. Ida.

15. Filed Dec 22, 1930 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH: Dec (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Died just before I arrived 9 A.M. 19..., that I last saw her alive on ..... 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) \ yrs. \ mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Beck M. D.

12/22/30 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moore, Ida. | Date of Burial: 12-23-30 19

20. Undertaker: Modern Mortuary - Blackfoot. | Address

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 5 1931

DO NOT WRITE IN THIS SPACE

State File No. 13035

PLACE OF DEATH

County of Bingham

City of Blackfoot — Registration District No. 121

Primary Registration District No. 2142 — Local Registrar's No. 185

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Katharina Spanbauer

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 20 1858

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	2	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Pro.

PARENTS

10. NAME OF FATHER Antone Earlacher

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Germany

12. MAIDEN NAME OF MOTHER Hallhouse

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) Germany

14. Informant Mrs Jos Spanbauer
(Address) Blackfoot Rt 3

15. Filed Dec 22 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Dec (Month) 21 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 21, 1930, to ....., 19.....
that I last saw her alive on Dec 21, 1930
and that death occurred, on the date stated above, at 9:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....

.....

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) J. O. Thompson M. D.

12-22 1930 (Address) Blackfoot Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Groveland Cemetery	Dec 23 1930

20. Undertaker E. J. Funk — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73081

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2141
Local Registrar's No. 18
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Edna Hawkes
(a) Residence. No. Thomas R.F.D #2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Harold D. Hawkes

6. DATE OF BIRTH (month, day and year) Nov. 11, 1898

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	1	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pingree Idaho

PARENTS

10. NAME OF FATHER Daniel C. Wood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Council Bluffs Iowa
12. MAIDEN NAME OF MOTHER Margaret Edwards
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Manchester England

14. Informant Harold D. Hawkes
(Address) Blackfoot Idaho R#2

15. Filed Jan. 16 1930 Wm. Wallace E. Furniss Registrar.

MEDICAL CERTIFICATE OF DEATH 6813

16. DATE OF DEATH 12 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 16, 1930, that I last saw her alive on Dec 16, 1930, and that death occurred, on the date stated above, at 12:20 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) C. O. Hawkes M. D.
12-16 1930 (Address) Blackfoot Idaho

19. Place of Burial, Cremation, or Removal: Thomas Riverside Cem. Date of Burial: 12/21 1930

20. Undertaker E. J. Funk Address Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73037

PLACE OF DEATH

County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 183

2. FULL NAME William Oscar Faulconer.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 25 1920

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	10	1	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work in school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Rockford (State or country) Idaho

PARENTS

10. NAME OF FATHER W E. Faulconer.
11. BIRTHPLACE OF FATHER (city or town) Graham (State or Country) Miss.
12. MAIDEN NAME OF MOTHER Jewel Mae Marshall
13. BIRTHPLACE OF MOTHER (city or town) Fort Worth (State or Country) Texas

14. Informant W. E. Faulconer
(Address) 4334 N. Hay Seattle Wn

15. Filed Dec 15 1930 Mrs. Nellie E. Pabie Registrar

MEDICAL CERTIFICATE OF DEATH 10 1a

16. DATE OF DEATH Dec (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Dec 14, 1930, that I last saw h~~im~~ alive on Dec 14, 1930, and that death occurred, on the date stated above, at 10:25 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical examination & Symptoms

(Signed) W. L. Eagen M. D.
Dec 15 1930 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Groen City Cemetery	Dec 16 1930

20. Undertaker E. J. Funk — Address Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73038

PLACE OF DEATH
County of Blaine
City of Hailey

Registration District No. 57
Primary Registration District No. 2022
(No. Hailey Clinical Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 37

RECEIVED JAN 10 1931

2. FULL NAME Jennie Griffith
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day and year) April 5 - 1870

7. AGE Years 60 Months 8 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS
10. NAME OF FATHER John Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Elizabeth Dickinson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Albert R Griffith Ketchum Ida

15. Filed 1-7, 1931 R. H. Wright Registrar.

MEDICAL CERTIFICATE OF DEATH 118B

16. DATE OF DEATH Dec. (Month) 14 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/9, 1930, to 12/14, 1930
that I last saw her alive on 12/14, 1930
and that death occurred, on the date stated above, at 2309 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Obstruction of small bowel from adhesions due to hysterectomy 12 yrs previous
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 12/9/30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E. W. [illegible], M. D.
12/15, 1930 (Address) Hailey, Ida

19. Place of Burial, Cremation, or Removal Ketchum - Ida
Date of Burial Dec 16 1930

20. Undertaker Harris & Amos Furn Co
Address Hailey

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13059

PLACE OF DEATH
County of Boise
City Placerville

Registration District No. 12
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alva Bert Lampshire

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 2 yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, ~~Widowed~~, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Olive Lampshire

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	7	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ore Mill Man
(b) General nature of industry, business, or establishment in which employed (or employer): Almalgamating Mill
(c) Name of employer: Talache Mines Inc

9. BIRTHPLACE (city or town) (State or country): Leadville Colorado

PARENTS

10. NAME OF FATHER: John Lampshire
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ireland

14. Informant ..... (Address) .....

15. Filed ....., 19..... Mrs. E. S. Robison Registrar.

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: 12 (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1930, to Dec 16, 1930
that I last saw him alive on Dec 16, 1930
and that death occurred, on the date stated above, at 1:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J. M. Beebe, M. D.
....., 19..... (Address) Emmett Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73047

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2135
(No. .....)
Local Registrar's No. 19

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Roy Calvin Dew

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb. 8, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Priest River Idaho.

PARENTS

10 NAME OF FATHER Elmer Dew
11 BIRTHPLACE OF FATHER (city or town) (State or country) Morrison Iowa
12 MAIDEN NAME OF MOTHER Ethel Bartges
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Elmer Dew
(Address) Priest River, Ida

15 Filed Dec. 16, 1930 R. E. Vessa Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
December 12, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1930, to Dec 15, 1930, that I last saw him alive on Dec 15, 1930, and that death occurred, on the date stated above, at 9:00A.m.

The CAUSE OF DEATH* was as follows:
Scarlet Fever
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms + Findings
(Signed) Harold C Storey, M. D.
Dec. 15, 1930 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Dec. 16 1930
20. Undertaker	Address
Moon Mortuary	Priest River, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73042

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 20

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Jacqueline Rose McGregor

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) June 27, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Priest River Idaho

PARENTS

10 NAME OF FATHER Geo. A. McGregor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Peshtigo Wisconsin

12 MAIDEN NAME OF MOTHER Grace McNeil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Josephine County Oregon.

14 Informant Georgi A McGregor
(Address) Priest River, Ida.

15 Filed Dec 26 1930 R. E. Wessa Registrar

MEDICAL CERTIFICATE OF DEATH 9

16 DATE OF DEATH
December 25, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1930, to Dec. 25, 1930
that I last saw her alive on Dec. 24-1930, 1930,
and that death occurred, on the date stated above, at 9:00A.m.

The CAUSE OF DEATH* was as follows:
pertussis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) L. J. Stauffer, M. D.
Dec. 26, 1930 (Address) Priest River, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
I. O. O. F. Cemetery	Dec. 27 1930
20. Undertaker	Address
Moon Mortuary	Priest River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13043

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 21

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Iris Rose Low

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Dec. 28, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				6

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Priest River
(State or country) Idaho

PARENTS

10 NAME OF FATHER John H. Low.

11 BIRTHPLACE OF FATHER (city or town) Camden
(State or country) Wash.

12 MAIDEN NAME OF MOTHER Margarette E. Shank

13 BIRTHPLACE OF MOTHER (city or town) Clarks
(State or country) Neb.

14 Informant John H. Low
(Address) Priest River, Idaho.

15 Filed Dec. 29 1930 R. E. Wesson
Registrar

MEDICAL CERTIFICATE OF DEATH 74W

16 DATE OF DEATH Dec. (Month) 28 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1930, to Dec 29, 1930, that I last saw h[illegible] alive on Dec 28, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Due to Puerperal Albuminuria

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Findings + symptoms

(Signed) Harold Lowey, M. D.

Dec 29, 1930 (Address) Priest River Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Woodmen Cemetery	Dec. 29 1930
20. Undertaker	**Address**
Moon Mortuary	Priest River, Ida.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7304

PLACE OF DEATH

County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Rawson Eldridge Dillman

(a) **Residence.** No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or ~~WIFE of~~) Anna Dillman

6 DATE OF BIRTH (month, day and year) April 3, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Round House Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Railway retired about 1 yr
(c) Name of employer

9 BIRTHPLACE (city or town) English
(State or country) Indiana

PARENTS

10 NAME OF FATHER Peter Dillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Landis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W E. Dillman
(Address) Priest River, Ida.

15 Filed Dec 31, 1930 R. E. Wessa
Registrar

MEDICAL CERTIFICATE OF DEATH 90

16 DATE OF DEATH
December 29, 1930
(Month) (Day) 19 (Year)

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h... alive on ..., 19...,
and that death occurred, on the date stated above, at 11:30A. m.

The CAUSE OF DEATH* was as follows:
Unknown Chronic Heart Disease
History frequent attacks.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) L. H. Moon Coroner.
Dec. 31, 1930 (Address) Sandpoint, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: I. O. O. F. Cemetery
Date of Burial: Jan. 2 1931

20. Undertaker: Moon Mortuary,
Address: Priest River, Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13045

PLACE OF DEATH
County of Bonner
City of Priest River
Registration District No. 85
Primary Registration District No. 2185
(No.)
Local Registrar's No. 23
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME William Henry Morr

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Frances Morr

6 DATE OF BIRTH (month, day and year) March 9, 1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cedar Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Lumbering
(c) Name of employer Humbird Lumber Co.

9 BIRTHPLACE (city or town) Unknown
(State or country) Nebraska

PARENTS
10 NAME OF FATHER Philip Morr
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Ellen Sears
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mochus Winkle
(Address) Kellogg Idaho

15 Filed Dec. 31, 1930 A. E. Weeks Registrar

MEDICAL CERTIFICATE OF DEATH 88B

16 DATE OF DEATH Dec. 31 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred, on the date stated above, at about 6 A. m.

The CAUSE OF DEATH* was as follows:
Probable chronic myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? None
(Signed) L. H. Moon Coroner M.D.
Dec 31, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
L. O. O. F. Cemetery	Jan. 3 1931
20. Undertaker	Address
Moon Mortuary	Priest River

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73046

PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 101
(No. ..., Parnell Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Daniel Mihar

(a) Residence. No. ... St. Priest River, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Parnell Hospital
(Address): Sandpoint, Idaho.

15. Filed Jan 1, 1931. Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH: December (Month) 30, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1930, to Dec. 30, 1930, that I last saw him alive on Dec. 29, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis. Chronic valvular heart disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Floyd G. Moore M. D.
Dec. 31, 1930 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River, Idaho.	Jan. 1, 1931

20. Undertaker	Address
L. G. Moon	Sandpoint, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73047

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 100

RECEIVED JAN 8 1931

2. FULL NAME Jackson Frank Watt.
(a) Residence. No. 920 Pine Street St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 12, 1930.

7. AGE Years Months Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint Idaho.

PARENTS
10. NAME OF FATHER Floyd Watt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sandpoint, Idaho.
12. MAIDEN NAME OF MOTHER Ida Kallio.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sandpoint, Idaho.

14. Informant Floyd Watt.
(Address) Sandpoint, Idaho. 920 Pine St.

15. Filed Dec 22, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 160

16. DATE OF DEATH Dec (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 21, 1930
that I last saw him live on Dec 20, 1930
and that death occurred, on the date stated above, at 1:30 a. m.
The CAUSE OF DEATH* was as follows:
Icterus
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Hydrocephalus
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Wm F. Tyler, M. D.
Dec 21, 1930 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Westmond, Idaho. Date of Burial Dec. 22, 1930

20. Undertaker L. S. Moon Address Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73043

PLACE OF DEATH
County of Bonner
City of Dover

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 99

(No. Dover Idaho.
(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 1931

2. FULL NAME Dennis Gene Cummings

(a) Residence. No. Dover St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 15 1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	3	5	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Colville
(State or country) Wash

PARENTS

10. NAME OF FATHER Carl Cummings
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Della Moy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mont

14. Informant Carl Cummings
(Address) Dover Idaho

15. Filed Dec 20, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH 8

16. DATE OF DEATH
Dec (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 6, 1930, to Dec 20, 1930
that I last saw him alive on Dec 19, 1930
and that death occurred, on the date stated above, at 1:30 A. m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia. Otitis Media

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) R S Cox M. D.
Dec 20, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lakeview Cemetery	12/21 1930
20. Undertaker	Address
Townsend Co	Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73049

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 76
Primary Registration District No. 2155
(No. Page Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 98

RECEIVED JAN 8 1931

2. FULL NAME Ernie E Severns

(a) Residence. No. Priest River St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Pearl Severns

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	4	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisconsin

PARENTS

10. NAME OF FATHER Brando Severns

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisc

12. MAIDEN NAME OF MOTHER Sarah Swinehart

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wisc

14. Informant Mrs Pearl Severns
(Address) Wardman Idaho

15. Filed Dec 19, 1930 by Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 117

16. DATE OF DEATH Dec 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1930, to Dec 18, 1930, that I last saw him alive on Dec 18, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Appendicitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? North of Priest River Idaho
Did an operation precede death? Yes. Date of Dec 17th
Was there an autopsy? No.
What test confirmed diagnosis? Operation.
(Signed) O E Page M. D.
Dec 19, 1930. (Address) Sandpoint Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Priest River	12/20 1930
20. Undertaker Townsend Co	Address Sandpoint

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73059

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2153

Local Registrar's No. 97

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME William H Welborn

(a) Residence. No. 223 N Ella St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 29 1912

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
18	10	20	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Arkansas
(State or country)

PARENTS

10. NAME OF FATHER Stroud Welborn

11. BIRTHPLACE OF FATHER (city or town) Ill
(State or Country)

12. MAIDEN NAME OF MOTHER Nancy Roller

13. BIRTHPLACE OF MOTHER (city or town) Texas
(State or Country)

14. Informant Mrs S W Welborn

(Address) 223 N Ella

15. Filed Dec 12, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 99a

16. DATE OF DEATH Dec 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Dec 9, 1930
that I last saw him alive on Dec 9 2:55P 1930
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Bronchitis-acute
Pleurisy with effusion Right

(duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY Liver clot
(Secondary)

(duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Stackhouse M. D.
12-12-, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	12/15/30 19
20. Undertaker Turnbull Co	**Address** Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73051

PLACE OF DEATH
County of BONNER
City of CARYWOOD

Registration District No. 78
Primary Registration District No. 2155
Local Registrar's No. 96

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME JAMES E. CLARK

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE
4. COLOR OR RACE WHITE
5. Single, Married, Widowed, or Divorced (write the word) MARRIED

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ELLA CLARK

6. DATE OF BIRTH (month, day and year) JAN. 1, 1846.

7. AGE Years 84 Months 11 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work FARMER
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) INDIANA

PARENTS
10. NAME OF FATHER RILEY CLARK
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN
12. MAIDEN NAME OF MOTHER MARY ONEIL
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant Sam Nelson
(Address) Sandpoint Idaho

15. Filed Dec 6, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Dec. (Month) 5, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1930, to Dec 3, 1930
that I last saw him alive on Dec 3, 1930
and that death occurred, on the date stated above, at 6 P.M. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? Clinical
(Signed) R S Ross, M. D.
Dec 6, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal PINECREST CEMETERY Date of Burial Dec. 7, 1930

20. Undertaker L. G. MOON Address SANDPOINT IDA

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73052

PLACE OF DEATH
County of Bonner
City of Sandpoint

Registration District No. 78
Primary Registration District No. 2155
(No. Parnell Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 95

RECEIVED JAN 3 1931

2. FULL NAME Thomas Delbert Rice

(a) Residence. No. Kootenai, Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 29, 1930

7. AGE Years Months Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Sandpoint
(State or country) Idaho

PARENTS

10. NAME OF FATHER Gunder Rice

11. BIRTHPLACE OF FATHER (city or town) Norway.
(State or Country)

12. MAIDEN NAME OF MOTHER Augusta Anderson.

13. BIRTHPLACE OF MOTHER (city or town) Mason
(State or Country) Wis.

14. Informant Gunder Rice
(Address) Kootenai, Idaho.

15. Filed Dec 5, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 118B

16. DATE OF DEATH Dec. (Month) 4, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1930, to Dec 4, 1930
that I last saw him alive on Dec 3, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) R. S. Kim M. D.
Dec. 5, 1930 (Address) Sandpoint

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lakeview Cemetery Date of Burial Dec. 5, 1930

20. Undertaker L. S. Moon Address Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73053

PLACE OF DEATH
County of BONNER
City of COLEMAN

Registration District No. 78
Primary Registration District No. 2155.

Local Registrar's No. 94

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and

RECEIVED JAN 8 1931

2. FULL NAME GILBERT JENSON HEMPHILL

(a) Residence. No. TALLMAN RANCH. St. HERMISTON OREGON
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	SINGLE

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 6, 1910

7. AGE	Years	Months	Days	If LESS than 1 day,
	19	11	24	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work DAY LABOR
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) PILOT ROCK
(State or country) OREGON

PARENTS

10. NAME OF FATHER ALFRED C. HEMPHILL

11. BIRTHPLACE OF FATHER (city or town) PILOT ROCK
(State or Country) OREGON

12. MAIDEN NAME OF MOTHER MARGARETTE OGILVIE

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) OREGON.

14. Informant Alfred C Hemphill
(Address) HERMISTON, OREGON.

15. Filed Dec 9, 1930 Viola Allen Registrar
Deputy

MEDICAL CERTIFICATE OF DEATH 170

16. DATE OF DEATH Nov. (Month) 30, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.
The CAUSE OF DEATH* was as follows:
SUICIDE BY FIREARMS

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) L. S. Moon CORONER
Dec. 1, 1930 (Address) Sandpoint Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
PINECREST CEMETERY	Dec. 9, 1930.

20. Undertaker L. S. Moon — Address Sandpoint, Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73054

PLACE OF DEATH
County of BONNER
City of PONDERAY

Registration District No. 78
Primary Registration District No. 2155

Local Registrar's No. 93

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME UNKNOWN MAN

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	UNKNOWN.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) UNKNOWN.

7. AGE	Years	Months	Days	If LESS than 1 day,
ABOUT	55			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work PROBABLE DAY LABOR
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) UNKNOWN

PARENTS

10. NAME OF FATHER UNKNOWN
11. BIRTHPLACE OF FATHER (city or town) (State or Country) UNKNOWN
12. MAIDEN NAME OF MOTHER UNKNOWN
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) UNKNOWN

14. Informant H. S. Moon
(Address) Sandpoint, Idaho.

15. Filed Dec 5, 1930 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH 199

16. DATE OF DEATH Nov. (Month) 5, (Day) 1930. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Death from exposure following blow on head with blunt instrument by hands of unknown person. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? Yes.
What test confirmed diagnosis? .....

(Signed) H. S. Moon. CORONER
Nov. 10, 1930. (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
PINECREST CEMETERY.	DEC 6, 1930

20. Undertaker MOON MORTUARY Address SANDPOINT, IDAHO.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73055

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2 v 8

2. FULL NAME Albert A. Miller

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married or Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6. DATE OF BIRTH (month, day and year) 1865

7. AGE Years 65 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Retail Coal.
(c) Name of employer J. A. Coy.

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant J. A. Coy.
(Address) Idaho Falls

15. Filed 12/30, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 88B

16. DATE OF DEATH Dec. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to death, 19..
that I last saw him alive on Dec 27, 1930.
and that death occurred, on the date stated above, at 9:10 a.m.
The CAUSE OF DEATH* was as follows: Myocarditis + Congestion of Lungs.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) R. J. Bulton M. D.
12-30, 1930 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida. Date of Burial Dec. 30 1930

20. Undertaker Jack A. Wood Address Idaho Falls.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73056

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 [illegible]

Local Registrar's No. 217

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jo Ann Clements
(a) Residence. No. Idaho Falls Ida. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Sept 27 1930
7. AGE Years 0 Months 2 Days 28 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Idaho Falls Ida.
(State or country)

PARENTS
10. NAME OF FATHER Elias Clements
11. BIRTHPLACE OF FATHER (city or town) Oxford Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Harriett Albright
13. BIRTHPLACE OF MOTHER (city or town) Big Timber Montana
(State or Country)

14. Informant Elias Clements
(Address) Idaho Falls Ida
15. Filed 12/29, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH December 27 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw her alive on ....., 19.....
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? History
(Signed) Dr. B. Fallen M.D.
Dec. 29, 1930 (Address) Conover Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls Ida
Date of Burial Dec 30 1930
20. Undertaker V. F. McHan
Address Idaho Falls Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73057

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2 12-6 Local Registrar's No. 25-6
(No. Spencer Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gorman Sliggs
(a) Residence. No. Sliggs Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Retta Sliggs

6. DATE OF BIRTH (month, day and year) December 21, 1904

7. AGE Years 26 Months Days 6 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerk in Drug Store
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS
10. NAME OF FATHER P. W. Sliggs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Elizabeth Lenyton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Byron Sliggs Sliggs, Idaho

15. Filed 12/27, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 50

16. DATE OF DEATH December 27, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1930, to Dec 26, 1930
that I last saw him alive on Dec-26, 1930
and that death occurred, on the date stated above, at 6-45 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Sarcoma of Post surface of Bladder & Ant surface of Rectum
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 14 30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
Dec-27, 1930 (Address) Idaho Falls Id

19. Place of Burial, Cremation, or Removal Sliggs, Idaho
Date of Burial Dec 30 1930

20. Undertaker Jack G. Wood
Address Idaho Falls

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73053

PLACE OF DEATH
County of Bonneville
City of Idaho Falls. Registration District No. 73
Primary Registration District No. 21N-0
Local Registrar's No. 247

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Florence Scoulton.

(a) Residence. No. Westland J. Street St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 24 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	2	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida

PARENTS

10. NAME OF FATHER W. B Scoulton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Topeka. Kansas
12. MAIDEN NAME OF MOTHER Caroline Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Florida. New Mexico.

14. Informant W B Scoulton.
(Address) Idaho Falls. Ida.

15. Filed Dec 27, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH December 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23. , 1930 to Death. , 19.....
that I last saw h[illegible] alive on Dec. 24 , 19.....
and that death occurred, on the date stated above, at 8 30 A. m.
The CAUSE OF DEATH* was as follows:
Pneumonia (Bronchs.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W Scoulton M. D.
12-26-, 1930 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
December 26 30	Idaho Falls

20. Undertaker	Address
D. F. McHan	Idaho Falls Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7365

Local Registrar's No. 24-4

PLACE OF DEATH

County of Bonneville. Registration District No. 73

City of Idaho Falls. Primary Registration District No. 21-0

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Theodore Scoulen.

(a) Residence. No. Jefferson & J. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 24-1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	0	2	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls. (State or country) Ida.

PARENTS

10. NAME OF FATHER W. B. Scoulen.

11. BIRTHPLACE OF FATHER (city or town) Topeka. (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Caroline Davis.

13. BIRTHPLACE OF MOTHER (city or town) Eldorado. (State or Country) New Mexico.

14. Informant W. B Scoulen.
(Address) Idaho Falls. Ida.

15. Filed Jan 2, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Dec 24, 19
that I last saw him alive on Dec 24, 19
and that death occurred, on the date stated above, at 10. 10. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchi)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [illegible] M. D.
12-26-, 1930 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls. Ida.	Dec 26. 1930

20. Undertaker T. F. McHan Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73069

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140

Local Registrar's No. 21-3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Bessie Jane Henrie

(a) Residence. No. Bear Ave St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 10 - 1930

7. AGE Years 0 Months 1 Days 16. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls. Ida.

PARENTS

10. NAME OF FATHER Peter Henrie.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pocatello. Ida.
12. MAIDEN NAME OF MOTHER Bessie Hunting
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Menan Ida

14. Informant Peter Henrie
(Address) Idaho Falls Ida

15. Filed Dec 27, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 101b

16. DATE OF DEATH December 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw her alive on ....., 19.....
and that death occurred, on the date stated above, at 8 am m.
The CAUSE OF DEATH* was as follows:
Pneumonia

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? History
(Signed) Dr. [illegible] Allen, M. D. Coroner
Dec. 27, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida
Date of Burial: 12/28 1930

20. Undertaker: V. F. McHan
Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7306

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21-D
Local Registrar's No. 2 V 2
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Annie Rosetta Frandsen

(a) Residence. No. ..... St. Iona, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Pete M. Frandsen

6. DATE OF BIRTH (month, day and year) Dec. 28 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	11	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lehi (State or country) Utah

PARENTS

10. NAME OF FATHER Isaac Cooper
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Rose Norton
13. BIRTHPLACE OF MOTHER (city or town) Lehi (State or County) Utah.

14. Informant Pete M. Frandsen (Address) Iona, Ida.

15. Filed 12/26, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 10 a

16. DATE OF DEATH December (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1930, to Dec 21, 1930,
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 10 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Rt. lobar pneumonia

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Cholecystitis

(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 14
Was there an autopsy?
What test confirmed diagnosis?

(Signed) [signature], M. D.
....., 19..... (Address) Idaho Falls Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Iona Idaho	Dec. 24 1930

20. Undertaker Jack A. Wood Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73062

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 2IN-D
Primary Registration District No.
(No. L. D. S. Hospital)
Local Registrar's No. 1-1
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Myrna Ruth Empey

(a) Residence. No. 10th St.
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 19, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	8	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Idaho.

PARENTS

10. NAME OF FATHER Arthur P. Empey.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lehi, Utah
12. MAIDEN NAME OF MOTHER Edna Hoy
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ammon, Ida.

14. Informant (Address) Arthur P. Empey 10th St. Idaho Falls

15. Filed 1/2/31, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH December (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1930, to Dec. 21, 1930, that I last saw h.e.r. alive on Dec. 21, 1930, and that death occurred, on the date stated above, at 1000 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bilateral Broncho-Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Pneumococcus Meningitis
..... (duration) ..... yrs. ..... mos. ? ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory and Spinal Ha
(Signed) Harry L. Wilson M. D
12/2x, 1930 (Address) Idaho Falls, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Dec. 24 19
20. Undertaker Jack A. Wood	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73063

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21V-0 Local Registrar's No. 21-0
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Irma Evelyn Corbett
(a) Residence. No. 303 14th St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 10 1914

7. AGE Years 16 Months 2 Days 14 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Grey Idaho.

PARENTS
10. NAME OF FATHER Clarence C. Corbett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Longmont. Colo.
12. MAIDEN NAME OF MOTHER Dulcie Sibbett
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grey, Ida.

14. Informant (Address) C. C. Corbett 303 14th Idaho Falls

15. Filed 12/26, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 131

16. DATE OF DEATH December (Month) 24 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to Dec 24, 1930
that I last saw her alive on Dec 23, 1930
and that death occurred, on the date stated above, at 5:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Uremia Poisoning

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Ch. Myocarditis & Ch. Nephritis
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? yes Date of March 1930
Was there an autopsy? No Insellectomy
What test confirmed diagnosis? Laboratory
(Signed) [signature], M. D.
12/26, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Idaho Falls, Ida. Date of Burial Dec. 26 1930

20. Undertaker Jack A. Wood. Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73064

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 2 1 V-0
Local Registrar's No. 247
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mack Jensen
(a) Residence. No. ..... St. Idaho Falls Rt #2
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 10 1930

7. AGE: Years — Months 6 — Days 14 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls Rt 2 Ida.

PARENTS

10. NAME OF FATHER: R. J. Jensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Mae Miller
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Thayne Wys.

14. Informant (Address): R. J. Jensen Idaho Falls Rt 2

15. Filed 12/26, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH December 24, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-23, 1930, to death, 19..
that I last saw him alive on Dec 24, 1930
and that death occurred, on the date stated above, at 9 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia (Bronchi)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) R J Sutton M. D.
12-26-, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Lincoln, Ida. — Date of Burial: Dec. 26 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13065

PLACE OF DEATH

County of Bonneville. Registration District No. 73

City of Idaho Falls. Primary Registration District No. 1214-a

Local Registrar's No. 24

(No. L-D-S Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirley Alice Williams

(a) Residence. No. 766 So. St. St.

(Usual place of abode)

Length of residence in city or town where death occurred. 0 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 4 1930.

7. AGE — Years: 0 | Months: 6 | Days: 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) ? (State or country)

PARENTS

10. NAME OF FATHER Geo Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.

12. MAIDEN NAME OF MOTHER Alice Ward.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Rock Springs Wyo.

14. Informant Geo W Williams

(Address) Idaho Falls. Ida.

15. Filed 12/24, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 22 1000a (Month) (Day) (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 22, 1930

that I last saw her alive on Dec 19

and that death occurred, on the date stated above, at 6.55P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Home

Did an operation precede death? Horocentesis Date of 12/21/30

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Exam

(Signed) [signature], M. D.

12/23, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls. Ida.	12/24 1930

20. Undertaker W. F. McHam. Address Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73066

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21 V-0
(No. L.D.S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 247

2. FULL NAME Joseph Frank Brinkman

(a) Residence. No. R.F.D. 7 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Brinkman

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 69 | Months 9 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10. NAME OF FATHER: Henry Brinkman
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.
12. MAIDEN NAME OF MOTHER: Gertrude Poeters
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Elizabeth Brinkman
(Address) Idaho Falls Ida.

15. Filed 12/23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH: December 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1930, to Dec 23, 1930
that I last saw him alive on Dec 23, 1930
and that death occurred, on the date stated above, at 7 30 A. m.
The CAUSE OF DEATH* was as follows:
Central Hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
12/23/30, 19 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Dec 27 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73067

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21[illegible]

Local Registrar's No. 246

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frans Oscar Eklund.

(a) Residence. No. 228 W. 14 St. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva. Elizabeth Eklund

6. DATE OF BIRTH (month, day and year): Nov 20 1864

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	0	29.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer): Mgr. Knitting

(c) Name of employer: factory in Sweden

9. BIRTHPLACE (city or town) (State or country): Dalan Sweden

PARENTS

10. NAME OF FATHER: Ole. Eklund.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Eva. E. Eklund.
(Address): Idaho Falls. Ida.

15. Filed 12/22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH: December 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Dec 19, 1930

that I last saw him alive on Dec 19, 1930

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

apoplexy and arteriosclerosis.

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. R. Godwyn[illegible], M. D.

Dec 22, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls. Ida.
Date of Burial: 12/21 1930.

20. Undertaker: V. F. McHan.
Address: Idaho Falls Idaho

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73068

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 21N-0
Local Registrar's No. 245
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes. Klymack.
(a) Residence. No. R.F.D. # 3. St. ....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): widowed.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year): Sept 15 1862
7. AGE — Years: 68 | Months: 3 | Days: 5 | If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer ....
9. BIRTHPLACE (city or town) (State or country): Galacz. Poland. Austria

PARENTS
10. NAME OF FATHER: Gaydeski.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Poland.
12. MAIDEN NAME OF MOTHER: Unknown.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland.

14. Informant: Louis Klymack.
(Address): Idaho Falls Ida.
15. Filed 1/2/31, 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 124

16. DATE OF DEATH: December 20 1930
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1930, to Dec 20, 1930
that I last saw her alive on Dec 19th, 1930
and that death occurred, on the date stated above, at 8:30 A. m.
The CAUSE OF DEATH* was as follows:
Enlargement of the liver complicated by paralysis of left side (duration) ....yrs. ....mos. 16 ds.
CONTRIBUTORY (Secondary) ....
(duration) ....yrs. ....mos. ....ds.
18. Where was disease contracted if not at place of death? ....
Did an operation precede death? no Date of ....
Was there an autopsy? no
What test confirmed diagnosis? ....
(Signed) Thomas C Wilson M. D.
Dec 22, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: Dec. 1930
20. Undertaker: W. F. McHan. | Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73069

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

Local Registrar's No. 244

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Sumner Foster

(a) Residence. No. 361 N. Water Ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Olive Foster

6. DATE OF BIRTH (month, day and year): Oct 3, 1856

7. AGE: Years 74, Months 2, Days 17. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Mgr. of Business

(c) Name of employer: Boise Payette Lebr Co.

9. BIRTHPLACE (city or town) (State or country): Evalston Illinois

PARENTS

10. NAME OF FATHER: Matthew Foster

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Leslie

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14. Informant: Mrs Sarah Olive Foster
(Address) Idaho Falls Ida

15. Filed 12/22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 10 1a

16. DATE OF DEATH: December 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1930, to Dec. 20, 1930

that I last saw him alive on ....., 19..

and that death occurred, on the date stated above, at 5.30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John O. Millar, M. D.

Dec. 22, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: 12/24 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73070

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21N 50
Local Registrar's No. 243
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edgar William Covington
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Apr. 13. 1909
7. AGE Years 21 Months 8 Days 7 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS
10. NAME OF FATHER W. H. Covington
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ogden Utah
12. MAIDEN NAME OF MOTHER Elizabeth Stoker
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) W. H. Covington
15. Filed 12/22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 24

16. DATE OF DEATH Dec (Month) 20 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1930, to Dec 20, 1930
that I last saw him alive on Dec 20, 1930
and that death occurred, on the date stated above, at 9:16P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Meningo Coccic meningitis,
..... (duration) ..... yrs. ..... mos. 5 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Rexburg
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) H Ray Hatch M. D.
Dec. 21, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Ogden Utah
Date of Burial Dec-23rd 19
20. Undertaker [signature]
Address Rexburg

Frid 8 P.M.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73074

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 13
Primary Registration District No. 2140
Local Registrar's No. 242
(No. L. D. S. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Percival James Tryon
(a) Residence. No. 540 E Halliday St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. ✓ yrs. ✓ mos. 17 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene Tryon

6. DATE OF BIRTH (month, day and year): Aug 17-1896

7. AGE: Years 34 | Months 3 | Days 26 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mgr Grain Co
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Washington

PARENTS

10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (city or town) (State or County): ?

14. Informant (Address): Mrs Irene Tryon Pocatello Idaho.

15. Filed Dec 16, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH: Dec (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1930 to Dec. 13, 1930
that I last saw him alive on Dec. 13, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Diphtheria (Tests all negative for 10 days before death)
Indefinite (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Broncho pneumonia
..... (duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death? Ririe
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) John O. Miller M. D.
Dec 16, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Pocatello Idaho. Date of Burial: Dec 1930

20. Undertaker: V. F. McHan. Address: Idaho Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. .....

CERTIFICATE OF DEATH 73

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. .....
Primary Registration District No. 21-0 Local Registrar's No. 241
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Marion Francis Crane

(a) Residence. No. ..... St. Rt #1
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Harriett Crane

6. DATE OF BIRTH (month, day and year) Dec. 3, 1869

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
61	0	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer + Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Nelson Crane
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pennsylvania
12. MAIDEN NAME OF MOTHER Mary Scurbe
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) Mrs. Julia H. Crane Idaho Falls Rt. #1

15. Filed 12/16, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 49

16. DATE OF DEATH December (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22, 1930, to Dec 11th, 1930
that I last saw h~~im~~ alive on Nov 22/30, 1930
and that death occurred, on the date stated above, at 6:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer (prostate gland)

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) G W Pendleton, M. D.
Dec 16, 1930 (Address) Idaho Falls Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Anthony Ida.	Dec. 15 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 2 1931

DO NOT WRITE IN THIS SPACE
State File No. 73029

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 2270 Local Registrar's No. 240
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Llon LeVell Griffin

(a) Residence. No. 13 E Street St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) October 28, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Emerson L. Griffin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Irene Ritter
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ammon, Idaho

14. Informant Emerson L. Griffin
(Address) Idaho Falls, Idaho

15. Filed 12/12, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 10 | b

16. DATE OF DEATH December 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 10, 1930, to Dec 10, 1930
that I last saw him alive on Dec 11, 1930
and that death occurred, on the date stated above, at 8 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. P. Sullivan M. D.
12-11, 1930 (Address) [illegible]

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Dec 12 193[illegible]
20. Undertaker: Jack A. Wood — Address: Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73821

PLACE OF DEATH
County of Bonneville.
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 239
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Luella Spalding

(a) Residence. No. Burton Ida. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Spalding.

6. DATE OF BIRTH (month, day and year) Sept. 9, 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) On Farm
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah

PARENTS

10. NAME OF FATHER Silas A. Buckland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah
12. MAIDEN NAME OF MOTHER Luella Pack
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant Frank Spaulding
(Address) Rexburg RFD #1

15. Filed Dec 10, 1930 Wm Townsend Registrar.

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH Dec. 7, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1930 to Dec. 7, 1930
that I last saw her alive on Dec. 7, 1930
and that death occurred, on the date stated above, at 8 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
aged arteriosclerosis
Chronic endocarditis
(duration) 20 yrs. — mos. — ds.
CONTRIBUTORY Bronchopneumonia
(Secondary)
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm O. Millar, M. D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal: Archer Cemetery
Date of Burial: 12/10 1930
20. Undertaker: Russell & Lamm
Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73075

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 23f
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161a

2. FULL NAME Stanley Graff
(a) Residence. No. ..... St. Rt. 3
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 4, 1930

7. AGE Years 0 Months 0 Days 0 If LESS than 1 day, 1 hour hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Chester Graff
11. BIRTHPLACE OF FATHER (city or town) Santa Clara, Utah.
(State or Country)
12. MAIDEN NAME OF MOTHER Winnie M. Terry
13. BIRTHPLACE OF MOTHER (city or town) Enterprise, Utah.
(State or County)

14. Informant (Address) Chester Graff Idaho Falls, Rt. #3

15. Filed 12/9, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 4 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec 4, 1930
that I last saw him alive on Dec 4, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH was as follows:
Anemia Prolapsed Cord
(duration) yrs. mos. 1 hr ds.

CONTRIBUTORY (Secondary) Premature 8 mo.
Anemia Mother (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? L D S Hosp
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. W. Nash M. D.
Dec 5, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Ammon, Ida. Date of Burial Dec. 5 1930

20. Undertaker Jack A. Wood Address Idaho Falls

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73076

PLACE OF DEATH
County of Bonneville
City of Iona

Registration District No. 73
Primary Registration District No. 2150 Local Registrar's No. 237
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Ambrose Edmond Rounds
(a) Residence. No. Iona Ida. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 36 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Rounds

6. DATE OF BIRTH (month, day and year) Aug 2 1868

7. AGE Years 62 Months 4 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Bountiful Utah.

PARENTS
10. NAME OF FATHER Wm Rounds
11. BIRTHPLACE OF FATHER (city or town) (State or Country) United States.
12. MAIDEN NAME OF MOTHER Amelia Longhurst
13. BIRTHPLACE OF MOTHER (city or town) (State or County) London England

14. Informant (Address) Mrs. Blanche Rounds Iona, Ida.

15. Filed 12/9 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 57

16. DATE OF DEATH December (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10 1928 to July 11, 1930
that I last saw h..... alive on July 11, 1930
and that death occurred, on the date stated above, at 8:40 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Diabete = Mellitus =
Indefinite
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic endocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) John O. Mellor, M. D.
..... 19..... (Address) Idaho Falls Idaho

19. Place of Burial, Cremation, or Removal Iona, Ida. Date of Burial Dec. 10 1930

20. Undertaker Jack A. Wood Address Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73067

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH
Registration District No. 73
Primary Registration District No. 21-D (No.)
Local Registrar's No. 236

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Pete Georgopoulos

(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Not Known

6. DATE OF BIRTH (month, day and year) 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Candy maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Greece

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Greece

14. Informant Mrs B. J. Allen
(Address) Idaho Falls, Idaho

15. Filed 12/16, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH 89

16. DATE OF DEATH December 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Found Dead in bed, probably, Angina Pectoris
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) B. J. Allen, Ida. Falls M. D.
Dec 5, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho — Date of Burial: Dec 7 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73078

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2170
Local Registrar's No. 235
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John L. Ekstrom
(a) Residence. No. ..... St. Arco, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Violet Ekstrom

6. DATE OF BIRTH (month, day and year) Apr. 15, 1892

7. AGE Years 38 Months 7 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) ?

PARENTS
10. NAME OF FATHER John L. Ekstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Annie Buntling
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah

14. Informant (Address) Violet Ekstrom Arco, Ida.

15. Filed 12/6, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 118B

16. DATE OF DEATH December (Month) 2 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-1, 1930, to Dec-2, 1930
that I last saw him alive on Dec-2, 1930
and that death occurred, on the date stated above, at 12 midnight

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Obstruction of bowels.
Caused by accident stuffed on Ice

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec 1 30
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
Dec 4, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal Arco, Ida
Date of Burial Dec. 5 1930

20. Undertaker Jack A. Wood
Address Idaho Falls

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73079

PLACE OF DEATH

County of Bonneville Registration District No. 73

City of Idaho Falls Primary Registration District No. 7 IV 2 Local Registrar's No. 234

(No. Spencer Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Schuldt.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white.	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24-1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	3	10.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER Henry Schuldt.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Gretchen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Carl Schuldt. Jr.
(Address) Idaho Falls Ida.

15. Filed 12/6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

45

16. DATE OF DEATH December 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct, 1930, to Dec 4, 1930
that I last saw h[illegible]ive on Dec 4, 1930
and that death occurred, on the date stated above, at 2.20 A. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Oct 30-30
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) [signature], M. D.
Dec 7, 1930 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ashton Iowa	Dec 8 1930
20. Undertaker	Address
V. F. Mc[illegible]	Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73080

Local Registrar's No. 283

PLACE OF DEATH
County of Bonneville. Registration District No. 73
City of Idaho Falls. Primary Registration District No. 2 1 4-0
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan Walker.
(a) Residence. No. 6½ miles N. of Idaho St. Falls.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 29 187[illegible]

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	0	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salt Lake City Utah

PARENTS
10. NAME OF FATHER Henry Bilman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Cleveland. Ohio.
12. MAIDEN NAME OF MOTHER Elizabeth Barnes.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England.

14. Informant C. J. Walker.
(Address) Idaho Falls Ida

15. Filed Dec 3, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

90

16. DATE OF DEATH December 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Dec 3, 1930
that I last saw h[illegible] alive on Nov 15, 1930
and that death occurred, on the date stated above, at 11:5 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart disease
(duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H. B. Grimes, M. D.
Dec 4, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Union Idaho	Dec 5 1930

20. Undertaker V. F. McKean. Address Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

W. R. West.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73081

RECEIVED JAN 2 1931

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2 1 4 0 Local Registrar's No. 232
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** G. E. Rostan

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	W.	Married.

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Sarah M. Rostan

6. DATE OF BIRTH (month, day and year) Nov. 18-1862

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS

10. NAME OF FATHER John Rostan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) France
12. MAIDEN NAME OF MOTHER N. K. ?
13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. K. ?

14. Informant (Address) Arthur Rostan Lorenzo Ida.

15. Filed 12/V-, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH 10 | B

16. DATE OF DEATH Dec. (Month) 3 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1930, to Dec 3, 1930, that I last saw him alive on Dec 3, 1930, and that death occurred, on the date stated above, at noon m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilation of Heart and Senility

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) T. R. West, M. D.
12/4, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal: Cedar Buttes — Date of Burial: Dec 6th 1930

20. Undertaker: Dean J. Miller — Address: Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECE... DEC 20 19..

DO NOT WRITE IN THIS SPACE
State File No. 73083

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0 Local Registrar's No. 230
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Frank Louis Clarke 201
(a) Residence. No. 490 — 6th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Clarke

6. DATE OF BIRTH (month, day and year): Oct. 23, 1881

7. AGE: Years 49 | Months 1 | Days 2 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Quartz Mine Operator
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Himself + Brother

9. BIRTHPLACE (city or town) (State or country): Boise Ida.

PARENTS

10. NAME OF FATHER: Patrick Henry Clarke
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Winnie M. Hopper
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Iowa.

14. Informant (Address): Wm E. Clarke Idaho Falls

15. Filed Nov. 28, 1930 Wm Fumand Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5, 1930, to Nov 25, 1930
that I last saw him alive on Oct 25, 1930
and that death occurred, on the date stated above, at 5:50 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Accidental - Fractured spine

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Bedsore - Urinary infection (duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X-ray
(Signed) Wm Fumand, M. D.
Nov 28, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal: Idaho Falls | Date of Burial: Nov. 28 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73084

DEC 20 193

PLACE OF DEATH
County of ~~Lincoln~~ Bonneville
City of ~~Alpine~~

Registration District No. 73
Primary Registration District No. 2150 Local Registrar's No. 229
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orville Ape 205 B
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 1878

7. AGE Years 52 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jewel City Kansas

PARENTS
10. NAME OF FATHER Charles Ape
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Ellen Poplin
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Tennessee

14. Informant (Address) Dale Ape Alpine, Wyoming

15. Filed Nov 25, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 10:20 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Not known
Probably
Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Evidence
(Signed) Dr. B. J. Allen M. D.
....., 19..... (Address) Coroner Idaho Falls

19. Place of Burial, ~~Cremation, or Removal~~ Alpine Wyo. | Date of Burial Nov. 26 1930

20. Undertaker None | Address
[signature] Coroner

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Orville Axe now lying buried in About 61 miles east southeast of Idaho Falls on Walter Pein Property ~~cemetery, in the City or Town of~~ NW¼ Section 19 T2S R46E County of _____ State of Idaho, who died on the 24 day of Nov., 1930 Aged 52 years ____ months ____ days, the cause of death being Not Known, Probably apopexy and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. B. J. Allen, Coronor attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private private or railway conveyance to Irwin cemetery in the City or Town of Irwin County of Bonneville State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Irwin it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho, this _____ day of _____, A.D. 19____.

permit issued to:

C. H. Hall
Hall-Grant Mortuary
Pocatello, Idaho

_____
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____ 19____.

_____
Health officer

Form DPH-48019

RECEIVED DEC 20 1930

DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73085

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chas E Elliott

66

(a) Residence. No. Cliff St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 28 1863

7. AGE: Years 67 | Months 2 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stone Mason
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant B. J. Allen
(Address) Idaho Falls Ida

15. Filed 11/21 1930 Lowry Fernand Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19.....
and that death occurred, on the date stated above, at 4:00 P.m.
The CAUSE OF DEATH* was as follows: Drinking Denatured Alcohol 4 days, nothing to eat.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Evidence
(Signed) Dr B Gallen M. D.
Nov 22 1930 (Address) Coroner Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 11/22 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73086

PLACE OF DEATH
County of Bonneville
City of Ucon

Registration District No. 73
Primary Registration District No. 214-0 Local Registrar's No. 227
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ann Matilda Smith 88 W
(a) Residence. No. Ucon, Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Smith.

6. DATE OF BIRTH (month, day and year) Aug. 17 1877

7. AGE Years 53 Months 3 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Henryville Utah.

PARENTS
10. NAME OF FATHER James B. Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Council Bluff Iowa
12. MAIDEN NAME OF MOTHER Ann Janette Brice
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lovele Utah.

14. Informant (Address) Jessie J. Misservy Idaho Falls Rt. 2.

15. Filed 11/24, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25, 1930, to Nov. 6, 1930
that I last saw her alive on Nov. 6, 1930
and that death occurred, on the date stated above, at 11:59 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Dropsy caused from simple Dilatation of heart, Chronic leakage, Hardened Arteries Primary cause, Chronic Endocarditis (Found dead in bed.) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) Dr. G. J. Allen D.C. Coroner
Nov. 24, 1930 (Address) Idaho Falls, Ida.

19. Place of Burial, Cremation, or Removal Wilford Ida. Date of Burial Nov. 25 1930

20. Undertaker Jack A. Wood Address Idaho Falls

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

REC'D DEC 20 1930

DO NOT WRITE IN THIS SPACE

State File No. 7308

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21V-0

Local Registrar's No. 226

(No. Spencer Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Frank H. Beeman

(a) Residence. No. 712 - 14th St.

(Usual place of abode.)

Length of residence in city or town where death occured 17 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Lida Beeman

6. DATE OF BIRTH (month, day and year): July, 13 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Geo. C. Tway.

9. BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10. NAME OF FATHER: Henry H. Beeman

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Angelia Archer

13. BIRTHPLACE OF MOTHER (city or town) (State or County): Illinois

14. Informant (Address): Ogden Beeman, Spokane, Wash.

15. Filed 11/22, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 19 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 19, 1930

that I last saw h~~e~~im alive on Nov 19, 1930

and that death occurred, on the date stated above, at 1 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? C

(Signed) H. B. Spencer, M. D.

Nov 22, 1930 (Address) Idaho Falls, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls	Nov. 23. 1930
20. Undertaker: Jack A. Wood	Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 13085

PLACE OF DEATH

County of Bonneville

City of Idaho Falls. Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. 22

(No. L. D. S. Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby. Hitchcock

(a) Residence. No. 1610 J and Jefferson St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. *If married, widowed, or divorced*
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 21, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls. (State or country) Ida.

PARENTS

10. NAME OF FATHER Willard Hitchcock

11. BIRTHPLACE OF FATHER (city or town) Moab. (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Lisa Scouten

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wyoming

14. Informant Willard Hitchcock (Address) Corner J. and Jefferson. Idaho Falls.

15. Filed 11/27, 1930 — Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November, 22 (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21, 1930, to Nov 22, 1930

that I last saw him alive on Nov 21, 1930

and that death occurred, on the date stated above, at 3 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Premature 6½ mo.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) A. P. Hitchcock, M. D.

Nov 27, 1930 (Address) Idaho Falls, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Ida.	Nov. 23 1930
20. Undertaker Jack A. Wood.	Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73089

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2140

Local Registrar's No. 224

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Maria L. Slover

(a) Residence. No. 140 - 4 St. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88 B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 16. 1852

7. AGE: Years 78 | Months 3 | Days 3. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nashville Tennessee

PARENTS

10. NAME OF FATHER Whittaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tennessee
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Lee Hughes
(Address) Idaho Falls Ida

15. Filed Nov 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19, 1930, to Nov 19, 1930
that I last saw her alive on Nov 19, 1930
and that death occurred, on the date stated above, at 9.30 m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
..... (duration) 4 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
....., 19..... (Address) [signature]

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida | Date of Burial: 11/23 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73090

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150 Local Registrar's No. 223
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161 b

2. FULL NAME Elise Tryfenia Stibbs
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) November 18, 1930

7. AGE Years | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS
10. NAME OF FATHER George E. Stibbs
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Tess Cannell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Jackson, Wyoming

14. Informant (Address) Mr. George E. Stibbs Idaho Falls, Idaho

15. Filed Nov 19, 1930 Wm Fumaird Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1930, to Nov 18, 1930
that I last saw h. wi alive on Nov 18, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Asphyxiation

(duration) ..... yrs. ..... mos. 1/3 ds.

CONTRIBUTORY (Secondary) Placenta Previa Magnolia

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? no
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Cecil Clive, M. D.
Nov 18, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho | Date of Burial Nov 19 1930

20. Undertaker Jack A. Wood | Address Idaho Falls

RECEIVED DEC 20

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73091

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls. Primary Registration District No. 210

Local Registrar's No. 222

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mattie Marie Anderson. 90

(a) Residence. No. 100 E 16 St. St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 2 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	8	13.	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10. NAME OF FATHER Christian H Christensen.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Mrs. Carolyn Robbins

(Address) Long Beach Cal.

15. Filed Nov 18, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 15 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 15, 1930 that I last saw her alive on Nov 15, 1930 and that death occurred, on the date stated above, at 4:45 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M. D.

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	Nov 19 1930

20. Undertaker V. F. McHan Address Idaho Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73092

REC... DEC 20 1930

PLACE OF DEATH

County of Bonneville. Registration District No. 23

City of Idaho Falls. Primary Registration District No. 2150

(No. L. D. S. Hospital.)

Local Registrar's No. 221

(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Lois M. Millard.

(a) Residence. No. Shelly R.D. 1 St.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 7-1930

7. AGE — Years: 0 | Months: 3 | Days: 10 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Shelly Idaho.

PARENTS

10. NAME OF FATHER: Arnold Millard

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Idaho Falls Ida

12. MAIDEN NAME OF MOTHER: Emma Bates

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Park City Utah

14. Informant: Arnold Millard.
(Address): Shelly Ida. R.D. 1.

15. Filed 11/18 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 17 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1930, to Nov. 17, 1930 that I last saw her alive on Nov. 17, 1930 and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Bilateral Broncho-pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) ... yrs. ... mos. 3 wks

18. Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry L. Watson M. D.

11/18, 1930 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida.	11/19 1930
20. Undertaker	Address
W. F. McHan.	Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC... DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73002

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 214

Local Registrar's No. 220

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME S Gustof Safstrom

100a

(a) Residence. No. 74 Holmes ave. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 20 1859.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer.

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: J. Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Carlson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden.

14. Informant: P. M. Safstrom.
(Address) Idaho Falls Ida

15. Filed Nov 18, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28, 19..., to Nov 18, 1930 that I last saw him alive on night of Nov 17th, 1930 and that death occurred, on the date stated above, at 3:25 A.m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia with hypostasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) G W Pendleton M. D.

11-18, 1930 (Address) Idaho Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida — Date of Burial: 11/21 1930

20. Undertaker: V. F. McHan — Address: Idaho Falls Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73095

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0 Local Registrar's No. 218
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Ivan George Lake
(a) Residence. No. Idaho Falls Ida St. 1000
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 29, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Ida

PARENTS

10. NAME OF FATHER Earnest Lake
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Central, Ida.
12. MAIDEN NAME OF MOTHER Violet M. Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Lee, Elko Co. Nevada.

14. Informant (Address) Mrs Earnest Lake. Idaho Falls.

15. Filed Dec 19, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 6, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29, 1930, to Nov 6, 1930
that I last saw h~~e~~ alive on Nov 2, 1930
and that death occurred, on the date stated above, at 3.30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia

(duration) yrs. mos. 20 ds.
CONTRIBUTORY (Secondary) Atelectasis Left ~~Upper~~ lung
(duration) yrs. mos. 37 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Thoracentesis Yes Date of Oct 10/193~~0~~
Was there an autopsy? No
What test confirmed diagnosis? X-ray & clinical

(Signed) [signature], M. D.
11/6, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls Ida	Nov. 9 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73096

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 217

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William E. Anderson

(a) Residence. No. 22 & Emerson St. 129
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 17-1907

7. AGE: Years 23. Months 9 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Telegrapher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O. S. L. R. R. Co.

9. BIRTHPLACE (city or town) (State or country) Idaho Falls Ida

PARENTS

10. NAME OF FATHER Otto Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Chicago Ill.
12. MAIDEN NAME OF MOTHER Ingrid Monson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Mrs Otto Anderson
(Address) Idaho Falls Ida.

15. Filed 11/9, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1930, to Nov. 6, 1930
that I last saw him alive on ....., 19....
and that death occurred, on the date stated above, at 6 30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 3 yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Chronic endocarditis
Indefinite (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. O. Mellor M. D.
Nov. 8, 1930 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Nov 9 1930

20. Undertaker: V. F. McHan Address: Idaho Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73097

RECE... DEC 2...

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 21 50 Local Registrar's No. 216
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

117

2. **FULL NAME** Rufus Harry Speas
(a) Residence. No. ..... St. Shelley Rt #1
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Louisiana M. Speas

6. DATE OF BIRTH (month, day and year) July 22 1889

7. AGE: Years 41, Months 3, Days 12. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carroll County Virginia

PARENTS

10. NAME OF FATHER Weley E. Speas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No. Carolina
12. MAIDEN NAME OF MOTHER Sarah Rigney
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Virginia

14. Informant (Address) Louisiana M. Speas Shelley Rt. #1, Ida.

15. Filed Nov 7, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 4 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Nov 4, 1930
that I last saw him alive on Nov 4, 1930
and that death occurred, on the date stated above, at 6:30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? Shelley Idaho
Did an operation precede death? Yes Date of Nov 1
Was there an autopsy? No
What test confirmed diagnosis? ✓
(Signed) [signature], M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal: Shelley, Ida. Date of Burial: Nov. 7 1930

20. Undertaker: Jack A. Wood Address: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73098

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 73
Primary Registration District No. 2150
Local Registrar's No. 215
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Torneten

8813

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 63 | Months 4 | Days 12. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10. NAME OF FATHER: S. O. Meppen
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Mary Graaffs
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14. Informant: Mrs Ida Fawzer
(Address) Idaho Falls Ida. R.D. 3

15. Filed Nov. 6, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1930, to Nov 5, 1930
that I last saw her alive on Nov 5, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pyloric Ulcer
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of Oct 14-30
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) [signature], M. D.
....., 19.... (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. | Date of Burial: 11/7 1930

20. Undertaker: V. F. McHan | Address: Idaho Falls Ida.

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73099

Registration District No. 73
Primary Registration District No. 21 N-0
Local Registrar's No. 214

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

48 B

2. FULL NAME Susan B Roxborough

(a) Residence. No. 224 - 5th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 7, 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	82.	6.	27.	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) London England.

PARENTS

10. NAME OF FATHER Henry Baldry.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Ethel R. Morrison
(Address) Idaho Falls Ida

15. Filed Nov 4, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26, 1930, to Nov 4, 1930
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 2.30 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Carcinoma of Breast amputation
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Utah.
Did an operation precede death? Yes Date of 1929
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Exam
(Signed) J. D. Ross, M. D.
Nov 24, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City Ut.	1930
20. Undertaker W. H. McHan.	Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO

DEC 26 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73100

PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 13

Primary Registration District No. 1350

(No. Spencer Hospital) Local Registrar's No. 213

(If death occurred in hospital or institution, give its name instead of street and number.)

1880

2. **FULL NAME** Flora Stewart Griffith

(a) Residence. No. ..... St. Iligo, Idaho

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of W. E. Griffith

6. DATE OF BIRTH (month, day and year) December 9, 1892

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	10	28	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Spanish Fork Utah

PARENTS

10. NAME OF FATHER Eli Stewart

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Springville, Utah

12. MAIDEN NAME OF MOTHER Hannah Case

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Springville, Utah

14. Informant (Address) Mrs. W. E. Griffith Iligo, Idaho

15. Filed Nov 10, 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 7 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 7, 1930, that I last saw h.. alive on Nov 7, 1930, and that death occurred, on the date stated above, at 4:30 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

accidental. auto accident

Dislocated head of Femur

Many Bruises & Laceration

shock (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W. S. Spencer M. D.

Nov 8, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Iligo, Idaho	Nov 10 1930
20. Undertaker	Address
Jack A. Wood	Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7310

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 210-2
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 21

170

2. FULL NAME A. Bonnie Croney
(a) Residence. No. 279 Cliff St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ~~M~~

6. DATE OF BIRTH (month, day and year) Oct. 15 1893

7. AGE: Years 37, Months 0, Days 14. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Basalt. Ida.

PARENTS

10. NAME OF FATHER: Aaron Croney
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Logan Utah
12. MAIDEN NAME OF MOTHER: Emma J Peterson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Copenhagen Denmark

14. Informant: A. E. Croney
(Address) Id

15. Filed Nov 4, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 29 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Oct 29, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 8.45 P m.
The CAUSE OF DEATH* was as follows: Violent — Gun-Shot wound through Head
(duration) yrs. mos. ds.
Suicidal?
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 45 Min ds.

18. Where was disease contracted if not at place of death? 279 Cliff St.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) [signature], M. D.
11/1, 1930 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Basalt. Ida. Date of Burial: Nov 2 1930

20. Undertaker: O. F. McHan Address: Idaho Falls Ida.

STATE OF IDAHO

RECEIVED DEC 20 1930

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7310

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 73
Primary Registration District No. 2-1-2-0 Local Registrar's No. 211
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank Orson Paul

(a) Residence. No. 100 a 9 St. Driggs, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 7, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER Frank O. Paul
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Newbury, Idaho
12. MAIDEN NAME OF MOTHER Virginia Thorpe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) St. Paul, Minnesota

14. Informant Frank O Paul
(Address)

15. Filed Nov. 1, 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 30 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 23, 1930, to Oct 30, 1930, that I last saw him alive on Oct 30, 1930, and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
see over.
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary) Empyema (whooping cough Bacilli)
(duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death? Driggs, Idaho
Did an operation precede death? yes Date of Oct 29.
Was there an autopsy? Thoracentesis + aspiration
What test confirmed diagnosis? Laboratory + Exam.

10/31, 1930 (Signed) [illegible] M. D.
(Address)

19. Place of Burial, Cremation, or Removal: Idaho Falls, Ida — Date of Burial: Nov. 1 1930

20. Undertaker: Jack A. Wood — Address: Idaho Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DEC 20 1930

DO NOT WRITE IN THIS SPACE
State File No. 73163

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 21-0
Local Registrar's No. 210
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

111 a

2. FULL NAME Rudolph Rindlesbacher
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs R Rindlesbacher

6. DATE OF BIRTH (month, day and year)

7. AGE 55 Years | Months 7 | Days 12 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS
10. NAME OF FATHER Bennedict Rindlesbacher
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Switzerland
12. MAIDEN NAME OF MOTHER Anna Barbara Christen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Switzerland

14. Informant (Address) Mrs Rindlesbacher Rexburg RFD 2

15. Filed Oct 30, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8, 1930 to Oct 29, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 6:25 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Exhaustion following Gastric Resection for Extensive Gastric Ulcer.
..... (duration) ..... yrs. 7 mos. 8 ds.
CONTRIBUTORY (Secondary) Starvation due to above
..... (duration) ..... yrs. ..... mos. 20 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Oct 14, 1930
Was there an autopsy? No
What test confirmed diagnosis? Xray, operation, laboratory
(Signed) J Ray Hatch, M. D.
Oct 29, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Rexburg Cemetery | Date of Burial 11/1 1930

20. Undertaker Russel R Fitamm | Address Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7311

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Bonneville
City of Idaho Falls
Registration District No. 23
Primary Registration District No. 214-2
Local Registrar's No. 209
(No. L. D. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Flavis

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Not Known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hay Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) L. D. S. Hospital Idaho Falls.

15. Filed Oct 30, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1930, to Oct. 24, 1930
that I last saw him alive on Oct. 24, 1930
and that death occurred, on the date stated above, at 12:15 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,
Cirrhosis of the Liver
Chronic Myocarditis (duration) yrs. mos. ds.
CONTRIBUTORY Unknown
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Not Known
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) Harry L. Wilson, M. D.
10/27, 1930 (Address) Idaho Falls,

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls	Oct. 30 1930
20. Undertaker Jack A. Wood	Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 30 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73105

PLACE OF DEATH

County of Bonneville
City of Idaho Falls. Registration District No. 73
Primary Registration District No. 2109
(No. L.D.S. Hospital) Local Registrar's No. 24
(If death occurred in a hospital or institution, give its name instead of street and number.) 126

2. FULL NAME Ann Elizabeth Larsen.

(a) Residence. No. Shelley Idaho St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Larsen.

6. DATE OF BIRTH (month, day and year): Feb. 10 - 1890

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
40	8	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Salt Lake City. Utah

PARENTS

10. NAME OF FATHER: T. J. Kearney.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland.
12. MAIDEN NAME OF MOTHER: Christensen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark.

14. Informant: John E. Larsen.
(Address) Shelley Idaho

15. Filed Dec 27, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 24" 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21 1930 to Oct 24 1930
that I last saw h[illegible] alive on Oct 23" 1930
and that death occurred, on the date stated above, at 12.50 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer (duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death? Shelley Idaho
Did an operation precede death? yes Date of Oct. 22 1930
Was there an autopsy? yes
What test confirmed diagnosis? Exploratory Incision

(Signed) F. E. Covey, M. D.
Oct 24, 1930 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shelley Idaho.	10/27 1930
20. Undertaker W. F. McHan	Address Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 20 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73106

PLACE OF DEATH
County of Bonneville Registration District No.
City of Idaho Falls Primary Registration District No. Local Registrar's No. 207
(No. St. L. D. Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

126.

2. FULL NAME Eva Anderson.
(a) Residence. No. 354 - 7. St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white.
5. Single, Married, Widowed, or Divorced (write the word): married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: wm anderson
6. DATE OF BIRTH (month, day and year):
7. AGE — Years: 42 | Months: 5 | Days: 3. | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (city or town) (State or country): Greensboro. N.C.

PARENTS
10. NAME OF FATHER: Edwards.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs Mary Packham
(Address): Ogden Utah.
15. Filed Oct 27 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 24 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from October 17, 1930, to Oct. 24, 1930
that I last saw h[er] alive on Oct. 24, 1930
and that death occurred, on the date stated above, at 10 20 P m.
The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver, Acute and chronic nephritis
(duration) unknown yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic alcoholism
(duration) many yrs. mos. ds.

18. Where was disease contracted if not at place of death? In Utah
Did an operation precede death? no Date of
Was there an autopsy? no What test confirmed diagnosis? Clinical
(Signed) L. L. Wilson M. D.
10/26, 1930 (Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls Ida. Date of Burial: Oct 27 1930
20. Undertaker: W. F. McHan Address: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73107

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2,0-0 Local Registrar's No. 206
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

161 (a)

2. **FULL NAME** Baby Boy Morgan
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 23, 1930

7. AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or 20 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Idaho Falls
(State or country) Idaho

PARENTS

10. NAME OF FATHER Earl Llellian Morgan
11. BIRTHPLACE OF FATHER (city or town) Archer Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Ada Hall
13. BIRTHPLACE OF MOTHER (city or town) Clark
(State or County)

14. Informant (Address) Earl Morgan

15. Filed Oct 24, 1930 (Sig.) [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 23 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 23, 1930, to October 23, 1930
that I last saw him alive on Oct. 23, 1930
and that death occurred, on the date stated above, at 3:00 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Premature Birth (26 weeks)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Edmund Crowley M. D.
Oct. 23, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal: Rigby Ida. | Date of Burial: Oct 24 1930

20. Undertaker: [illegible] | Address: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73108

PLACE OF DEATH
County of Bonneville
City of Ririe

Registration District No. 13
Primary Registration District No. 2150 Local Registrar's No. 205
(No.) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lyla Maud Ricks
(a) Residence. No. Ririe Star Route St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 5 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) May 19 - 1930

7. AGE Years Months 5 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Ririe Star Route

PARENTS
10. NAME OF FATHER Wm Chas. Ricks
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan Ut.
12. MAIDEN NAME OF MOTHER Catherine Ellen Humphrey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Redman Ut.

14. Informant (Address) Dr. Abbott's records W. R. Abbott M.D.

15. Filed Oct 21, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 20 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 20, 1930
that I last saw her alive on Oct 20, 1930
and that death occurred, on the date stated above, at 4:10 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? Ririe Star Route
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W. R. Abbott, M. D.
Oct 31, 1930 (Address) Ririe Ida.

19. Place of Burial, Cremation, or Removal Rexburg Ida
Date of Burial Oct 22 1930

20. Undertaker J. Woods
Address Sidney Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73109

PLACE OF DEATH
County of Bonniville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No.)
Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 193

2. FULL NAME Mary Ella Marlow

RECEIVED JAN 8 193

(a) Residence. No. Rexburg St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years 14 Months 6 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Madison

PARENTS

10. NAME OF FATHER John Marlow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Myrtle Mock
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oklahoma

14. Informant (Address) Myrtle Mock

15. Filed 12/ 19 30 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 9 (Month) (Day) 19 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from I did not see the patient alive 19 to 19
that I last saw h alive on 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
unknown. autopsy was negative. stomach sent to state lab for examination
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Rexburg Ida
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) H D Spencer M. D.
Dec 24 19 30 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal Rexburg Ida
Date of Burial Dec. 23 1930

20. Undertaker [signature]
Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73110

PLACE OF DEATH
County of Bonniville
City of Idaho Falls

Registration District No. 101
Primary Registration District No. 2122 Local Registrar's No. 79
(No.) 126
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Shirley Wilding

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years I Months 4 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Rexburg
(State or country) Idaho

PARENTS

10. NAME OF FATHER Earl R. Wilding
11. BIRTHPLACE OF FATHER (city or town) Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Mahalia Nave
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or County)

14. Informant (Address) Earl R. Wilding
Sugar City-Idaho

15. Filed Jan 2, 1931 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 28, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-27, 1930, to Dec-28, 1930
that I last saw her alive on Dec-28, 1930
and that death occurred, on the date stated above, at 6:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec-28 30
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) H D Spencer, M. D.
Dec-30, 1930 (Address) Idaho Falls Ida

19. Place of Burial, Cremation, or Removal Sugar City.
Date of Burial 19

20. Undertaker Alvin Keller
Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
Registration District No. 79
Primary Registration District No. 2156
(No.) 197
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 7311

Local Registrar's No.

2. FULL NAME Llewellyn Sumner Curtis Church

(a) Residence. No. St. North Anson, Maine
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. About 45 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 19, 1867.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Embden, Maine

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Mrs. Violet Robinson
(Address) Bonners Ferry, Idaho.

15. Filed Oct. 30, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 26, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Homicide
Rifle shot wound of head
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Lewis Bonnell M. D.
Oct 30, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Idaho.	Nov. 10, 1930

20. Undertaker H.R. Crouch, Address Bonners Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 13 [illegible]

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7311[illegible]

PLACE OF DEATH

County of Boundary. Registration District No. 79

City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No.

(No. Bonners Ferry Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

101A

2. FULL NAME Mae Wolford

(a) Residence. No. St. Spokane, Wn

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 55 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant

(Address)

15. Filed Oct. 27, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1930, to Oct. 24, 1930, that I last saw h[illegible] alive on Oct. 24, 1930, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical signs.

(Signed) E. E. Fry, M. D.

Oct. 27, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida	Nov 4 1930
20. Undertaker	Address
R. P. Crouch,	Bonners Ferry,

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7313

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Edward Mackey,

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 22, 1928.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2		14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Bonners Ferry
(State or country) Idaho.

PARENTS

10. NAME OF FATHER William Mackey

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Minn.

12. MAIDEN NAME OF MOTHER Beulah Woodward

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Minn.

14. Informant Mrs. Beulah Worley,
(Address) Bonners Ferry, Ida.

15. Filed Oct 6-, 1930. E. E. Fry
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 6, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1-, 1930, to Oct. 6-, 1930
that I last saw h[illegible] alive on Oct. 6 -, 1930
and that death occurred, on the date stated above, at 2:40P. m.
The CAUSE OF DEATH* was as follows:

Uremic Coliko

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? yes.
What test confirmed diagnosis? .....

(Signed) E. E. Fry, M. D.
Oct. 6-, 1930 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Oct. 7, 1930

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7314

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.

PLACE OF DEATH

County of Boundary
City of Porthill
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Effie Kate French,

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of H.A. French

6. DATE OF BIRTH (month, day and year) July 12, 1873

7. AGE	Years	Months	Days	If LESS than 1 day,
	57	2	17	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c). Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10. NAME OF FATHER John Skivington

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Keever

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ohio

14. Informant H.A. French,
(Address) Porthill, Idaho.

15. Filed Sept. 30, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 29, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 1: A. m.

The CAUSE OF DEATH* was as follows:
Embolism (Cardiac)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of ribs (accidental fall) Injury to lung.
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? History.

(Signed) , M. D.
Sept. 30, 1930. (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Porthill, Idaho.	Oct. 3, 1930.

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73115

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

114

2. FULL NAME William McLeod

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 2, 1923.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
7	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Terrace, B.C. Canada

PARENTS

10. NAME OF FATHER Donald McLeod,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana
12. MAIDEN NAME OF MOTHER Ethel French
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant Donald McLeod
(Address) Bonners Ferry, Ida.

15. Filed Sept. 28, 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 26, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15, 1930, to Sept 26, 1930,
that I last saw h.im alive on Sept 26, 1930
and that death occurred, on the date stated above, at 6:30 P. m.
The CAUSE OF DEATH* was as follows:
Acute Gastroenteritis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) Chas Bonsall, M. D.
Sept 27, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Sept. 30, 1930

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7314

PLACE OF DEATH

County of Boundary
City of Bonners Ferry,
Registration District No. 79
Primary Registration District No. 2156
(No. 31)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thomas F. Metcalfe.

(a) Residence. No. St. Chesterfield, Ill.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 5, 1863.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Frank Metcalfe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Jane Hough
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Joseph F. Metcalfe,
(Address) Chesterfield, Ill.

15. Filed Sept. 27-1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 26, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 3 - 1930, to Sept. 26-1930.
that I last saw him alive on Sept. 26 - 1930
and that death occurred, on the date stated above, at 7: P.M.m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Chesterfield, Ill.
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Physical examination.

(Signed) [signature], M. D.
Sept. 27-1930 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Chesterfield, Ill.	

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7314

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No. 114)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dora May McLeod,

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 19-1927.

7. AGE	Years	Months	Days	If LESS than 1 day,
	3	2	3	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Ida.

PARENTS

10. NAME OF FATHER Donald McLeod

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Montana

12. MAIDEN NAME OF MOTHER Ethel French

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich.

14. Informant Donald McLeod

(Address) Bonners Ferry, Ida.

15. Filed Sept. 22, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 22, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19, 1930, to Sept 22, 1930, that I last saw her alive on Sept 22, 1930, and that death occurred, on the date stated above, at 8:15 A.m.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [signature], M. D.

Sept 22, 1930 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Sept. 23, 1930

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73118

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

127

2. FULL NAME Ray Ferguson,

(a) Residence. No. St. Porthill, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Edna Ferguson,

6. DATE OF BIRTH (month, day and year): Feb, 22, 1885.

7. AGE: Years 45, Months 6, Days 19. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Iowa.

PARENTS

10. NAME OF FATHER: Isaac Ferguson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vermont.
12. MAIDEN NAME OF MOTHER: Julia Carrington.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Mrs. Edna Ferguson,
(Address) Porthill, Idaho.

15. Filed Sept. 11, 1930. E. E. Frey, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 10, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1930, to Sept. 10, 1930.
that I last saw him alive on Sept. 10, 1930.
and that death occurred, on the date stated above, at 2: P.M.
The CAUSE OF DEATH* was as follows:
Ilio-Colitis
(duration) yrs. 9 mos. ds.
CONTRIBUTORY (Secondary) alcoholism (?)
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Porthill, Idaho.
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis?
(Signed) E. E. Frey, M. D.
Sept. 11, 1930. (Address) Bonners Ferry, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Idaho. Date of Burial: Sept. 13, 1930

20. Undertaker: H.R. Crouch, Bonners Ferry, Idaho. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

[redacted]

DO NOT WRITE IN THIS SPACE

State File No. 73119

County of Boundary

City of Bonners Ferry

Registration District No.

Primary Registration District No.

(No. County Farm.) and number.)

(If death occurred in a hospital or institution, give its name

Local Registrar's No.

31

2. FULL NAME Thomas Armstrong,

(a) Residence. No. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. 15 yrs. mos. ds. Ho if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White,	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Armstrong

6. DATE OF BIRTH (month, day and year) April 6, 1900

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	5	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10. NAME OF FATHER Wm. Armstrong,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland.

12. MAIDEN NAME OF MOTHER Elizabeth Ward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Mrs. Gladys Armstrong

(Address) Bonners Ferry, Idaho.

15. Filed Sept. 12, 1930. E. E. Fry Registrar

EDICAL CERTIFICATE OF DEATH

16 EATH Sept. 10, 1930. 19 (Month) (Day) (Year)

17 CERTIFY, That I attended deceased from , 1925, to Sept. 10, 1930.

th im alive on Sept. 10, 1930.

an d that death occurred, on the date stated above, at 7; P.M. m.

Th CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary hemorrhage

(duration) yrs. mos. 1 ds.

18. Wh ere was disease contracted if no at place of death?

Did an op eration precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical examination

(Signed) E. E. Fry, M. D.

Sept. 12, 1930 (Address) Bonners Ferry, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Paradise Cemetery	Sept. 13, 1930

20. Undertaker H.R. Crouch, Bonners Ferry, Ida. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 12 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73120

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

74a

2. FULL NAME C.W. Mays.

(a) Residence. No. County Farm St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 75 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Hospital Records
(Address) Bonners Ferry, Ida.

15. Filed Sept. 9, 1930 E. E. Frey Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 6, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept., 1929, to Sept. 6, 1930.
that I last saw him alive on Sept. 6, 1930.
and that death occurred, on the date stated above, at 3 P. m.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) E. E. Frey, M. D.
Sept. 9, 1931 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. | Date of Burial: Sept. 10, 1930

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. | Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 731

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

31

2. FULL NAME Charles Wyrick

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 54			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Frank Wyrick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Rachel Burke

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14. Informant Frank Richardson
(Address) Bonners Ferry, Idaho.

15. Filed Aug. 1st, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 31, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 -, 1930, to July 31 -, 1930
that I last saw h[illegible] alive on July 31 -, 1930
and that death occurred, on the date stated above, at 11:30A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) E. E. Fry, M. D.

Aug. 1st 1930 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Aug. 2, 1930

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73[illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

169

2. **FULL NAME** Knut Rodell

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 21 - 1879

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Nisdalen
(State or country) Norway

PARENTS

10. NAME OF FATHER Ole K. Rodell
11. BIRTHPLACE OF FATHER (city or town) Nisdalen
(State or Country) Norway
12. MAIDEN NAME OF MOTHER Kari Vike
13. BIRTHPLACE OF MOTHER (city or town) Eisfjorden
(State or County) Norway

14. Informant (Address) Sigrid Le Dirach 2507 Farnam Omaha Nebr.

15. Filed July 29, 1930 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Suicide by Drowning

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dementia
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Km Bowell M. D.
July 29, 1930 (Address) Bonners Ferry Ida Coroner

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry Idaho	Aug 5 1930

20. Undertaker	Address
H Klerouch	Bonners Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECE[illegible] JAN 2 1931

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 73123

Local Registrar's No. .....

88 V

2. FULL NAME Robert Nelson,

(a) Residence. No. ..... St. Naples, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White,

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9, 1861

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
69	1	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10. NAME OF FATHER: Nelson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Clarence Nelson,
(Address) Wallace, Idaho.

15. Filed July 25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Chronic Myocardial Insufficiency (Sudden death)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Previous physical examination

(Signed) [signature], M. D.

July 25, 1930 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: McArthur, Idaho. Date of Burial: July 26, 1930. 19

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73124

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156 Local Registrar's No. .....

(No. Bonners Ferry Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

206

2. **FULL NAME** Baby Clark

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 16-1930

7. AGE Years Months Days Still born If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Idaho

PARENTS

10. NAME OF FATHER David Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wash

12. MAIDEN NAME OF MOTHER Thelma Sweet

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mich

14. Informant (Address) David Clark Leonia, Idaho

15. Filed July 16, 1930 E. E. Fry Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 16 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Stillborn
(Placental infarcts)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. E. Fry, M. D.

July 16, 1930 (Address) Bonners Ferry, Ida.

19. Place of Burial, Cremation, or Removal Bonners Ferry, Ida. Date of Burial July 16-1930

20. Undertaker A. R. Crouch Address Bonners Ferry Idaho.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO

REGISTERED JAN 2 1931

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12195

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No. 167)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William C. Reid.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Ellen Reid.

6. DATE OF BIRTH (month, day and year) April 9, 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Clerical Work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Boundary County.

9. BIRTHPLACE (city or town) Watertown,
(State or country) New York

PARENTS

10. NAME OF FATHER John Reid,

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Canada

12. MAIDEN NAME OF MOTHER Nora Collins

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Unknown

14. Informant Mrs. Ellen Reid.
(Address) Bonners Ferry, Ida.

15. Filed July 15, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 13, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Suicide
Carbon Monoxide Poisoning
(Hose from exhaust into car)

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas Boswell Coroner M. D.
July 14, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal Date of Burial
Spokane Wash. July 17, 30

20. Undertaker Address
H.R. Crouch, Bonners Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73126

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. 185
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Gordan P. Klaus
(a) Residence. No. ..... St. Porthill, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar 16, 1910

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
20	3	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sandpoint, Idaho.

PARENTS

10. NAME OF FATHER J.P.Klaus
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Edith Hall.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wisconsin.

14. Informant (Address) Mrs. Edith Klaus, Porthill, Idaho.

15. Filed July 12, 1930. E. E. Fry Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12, 1930. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 7 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Basilar fracture of Skull - accidental fall from a telephone pole.
(duration) ..... yrs. ..... mos. 16 hrs.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Near Port Hill, Ida.
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination
(Signed) E. E. Fry, M. D.
July 12, 1930 (Address) Bonners Ferry, Ida.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida.
Date of Burial: July 13, 1930

20. Undertaker: H.R. Crouch. Bonners Ferry, Ida.
Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 731[illegible]

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. 749
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Amma Skaar,

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 13 yrs. mos. ds. How long in U. S. if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 9, 1863

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	1	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Richard Peters, Bonners Ferry, Ida.

15. Filed July 13, 1930 E B Ing Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 12, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to July 12, 1930
that I last saw her alive on July 11, 1930
and that death occurred, on the date stated above, at 5:A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arthritis deformans

(duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) Chas Bonnell, M. D.
July 13, 1930 (Address) Bonners Ferry

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry Ida.	July 14, 1930.
20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73128

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH
Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emerson Welch, 90

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Mar. 28, 1875.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	3	3	

8. OCCUPATION OF DECEASED Day Laborer & Teamster
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10. NAME OF FATHER Thomas Welch

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant ..... (Address) Clarence Welch, Bonners Ferry, Idaho.

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 1, 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30, 1930, to July 1, 1930
that I last saw h.im alive on July 1, 1930
and that death occurred, on the date stated above, at 8:10A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rupture of left Ventricle

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Clarence Welch, M. D.
July 2, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	July 3, 30
20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73129

PLACE OF DEATH
County of Boundary
City of Bonners Ferry,

Registration District No. 79
Primary Registration District No. 2156
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

qD

2. FULL NAME Joseph Lowry Meddock,

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Meddock

6. DATE OF BIRTH (month, day and year) Jan. 28, 1875

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	6	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Spokane International Ry. Co.

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10. NAME OF FATHER Gale Meddock
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Sarah Ann Wood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant Dan Meddock,
(Address) Bonners Ferry, Ida.

15. Filed Aug. 20, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 19, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October, 1929, to Aug 19, 1930
that I last saw him alive on Aug 19, 1930
and that death occurred, on the date stated above, at 6:A.M. m.
The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease
Mitral Regurgitation
?
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Myocardial degeneration
(duration) yrs. 10 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No - Physical Examination
What test confirmed diagnosis?
(Signed) Ed Gorrell M. D.
Aug. 20, 1930 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Aug. 22, 1930.

20. Undertaker — Address
H.R. Crouch, Bonners Ferry, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73130

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

161 a

2. FULL NAME Baby Gerrin

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 7-1930

7. AGE Years Months Days If LESS than 1 day, 12 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry Ida.

PARENTS

10. NAME OF FATHER T. C. Gerrin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) La.
12. MAIDEN NAME OF MOTHER Lillian Saddler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wash.

14. Informant T. C. Gerrin
(Address) Bonners Ferry Ida

15. Filed Aug. 7, 1930 E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw her alive on Aug. 7, 1930.
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Prematurity (6 mos.)
(Confinement due to a fall)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no. Date of .....
Was there an autopsy? no.
What test confirmed diagnosis? .....
(Signed) E. E. Fry, M. D.
Aug. 7, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida — Date of Burial: Aug. 7 1930

20. Undertaker: H. R. Cronch — Address: Bonners Ferry, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 8 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7131

PLACE OF DEATH
County of Teton
City of Driggs

Registration District No. 77
Primary Registration District No. 9176

Local Registrar's No. 13

(No. 41)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline K. Nielsen

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of James Nielsen

6. DATE OF BIRTH (month, day and year) May 25 - 1875

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	6	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Weston Ida

PARENTS

10. NAME OF FATHER Hans Nofoed

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Thora Andersen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant James Nielsen
(Address) Driggs Idaho

15. Filed 12-15-1930 Martha Marker Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1930, to Dec 7, 1930
that I last saw her alive on Dec 7, 1930
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:
Intestinal toxemia and shock
(duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) Adhesions in abdomen, age
Cholotomy (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) ..... M. D.
12/9, 1930 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Cache & Clawson	Dec 10 1930
20. Undertaker	**Address**
Vern J. Keller	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73132

PLACE OF DEATH
County of Teton
City of Driggs.
Registration District No. 77
Primary Registration District No. 2176
Local Registrar's No. 14
(No. 126)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Hans Peter Larsen

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	Married

5a. ~~If married, widowed, or divorced~~
HUSBAND of
~~(or) WIFE of~~ Melvina Larsen

6. DATE OF BIRTH (month, day and year) Sept 6-1892

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
38	3	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER A. C. Larsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Annie M. Sorenson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant A. L. Larsen
(Address) Driggs Ida.

15. Filed 12-15-, 1930 Martha Marker Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 10-, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
12-7, 1930, to 12-10, 1930
that I last saw ~~him~~ alive on 12-10, 1930
and that death occurred, on the date stated above, at 10:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) ....yrs. ....mos. 1 ds.
CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) ....yrs. ....mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. O. Parkinson, M. D.
12-12-, 1930 (Address) Driggs Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Darbys	Dec 13 1930
20. Undertaker	Address
Mark J. Keller	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

REC[illegible] DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7319

Registration District No. 29
Primary Registration District No. 515

Local Registrar's No.

PLACE OF DEATH
County of Boundary
City of Porthill

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Winifred King

90

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Glen W. King

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	1	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Glen W. King
(Address) Porthill Idaho

15. Filed May 30 - 1930 E. E. Long Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Coronary Sclerosis ? ? ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) A. W. Bonner M. D.
May 30 - 1930 (Address) Bonners Ferry Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Spokane, Wash.	
20. Undertaker	Address
A. R. Crouch	Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73195

PLACE OF DEATH
County of Boundary
City of Eastport

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Adolph Frederick Henry de Lespinasse 88 b
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. 0 mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of E E de Lespinasse

6. DATE OF BIRTH (month, day and year) July 18 - 1873

7. AGE Years 56 Months 10 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U. S. Government

9. BIRTHPLACE (city or town) (State or country) Shenandoah, Iowa

PARENTS
10. NAME OF FATHER A F H de Lespinasse
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known (Netherlands) Holland
12. MAIDEN NAME OF MOTHER Elizabeth E Morton
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New Germany Nova Scotia

14. Informant (Address) B M de Lespinasse. Eastport Idaho

15. Filed 5/26, 1930 E E [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 25, 1930. (Month) (Day) (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocardial Disease (Sudden death)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? History of Cardiac Distress
(Signed) Ruth Bowell M. D.
May 26, 1930. (Address) Bonners Ferry Idaho Coroner

19. Place of Burial, Cremation, or Removal Seattle, Wash. Date of Burial 19

20. Undertaker H.R. Crouch, Bonners Ferry, Ida. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73136

RECEIVED DEC 30 1930

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. 31
(No. Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mathias J. Guthrie
(a) Residence. No. St. Copeland, Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 23 - 1854

7. AGE Years 73 Months 7 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming & day
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10. NAME OF FATHER R. J. Guthrie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Eliza Poland
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Virginia

14. Informant (Address) John Guthrie Copeland Ida

15. Filed May 7th 1930. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1930, to May 14, 1930
that I last saw him alive on May 15, 1930
and that death occurred, on the date stated above, at 4:15 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) E. E. Vey, M. D.
May 17 1930 (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal Copeland, Idaho. Date of Burial May 19 1930

20. Undertaker H. R. Crouch, Bonners Ferry, Ida Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 1930

ST O

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7313

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. 8
(No. Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

111

2. FULL NAME William Roy Van Arlsdale
(a) Residence. No. ..... St. Troy, Mont
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Van Arlsdale
6. DATE OF BIRTH (month, day and year) Jan. 4-1865
7. AGE Years 65 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railway Cashier
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer G. N. Ry. Co.
9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER David Van Arlsdale
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Sarah Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) L. W. Van Arlsdale Whitefish, Mont.
15. Filed May 12, 1930 E. E. Fry Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 11 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 16th, 1929, to May 11th, 1930
that I last saw him alive on May 11th, 1930
and that death occurred, on the date stated above, at 6:15 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of duodenum and mesentery of small intestine (Secondary)
..... (duration) ..... yrs. 6 mos. ..... ds.
CONTRIBUTORY (Secondary) Duodenal ulcer -
..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Troy, Montana
Did an operation precede death? no. Date of .....
Was there an autopsy? no.
What test confirmed diagnosis? Physical signs.
(Signed) E. E. Fry, M. D.
May 12, 1930 (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal Troy, Mont. Date of Burial May 1930
20. Undertaker H. R. Crouch Address Bonners Ferry, Ida

STATE OF IDAHO

RECEIVED DEC 30 1930

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73138

PLACE OF DEATH

County of Boundry

City of Bonners Ferry

Registration District No. 29

Primary Registration District No. 3156 Local Registrar's No. 1

(No. Bonners Ferry Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

18

2. **FULL NAME** Harry Higgins

(a) Residence. No. (Usual place of abode.) St. Troy, Mont. (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 8 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Not known

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 67 "			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not known

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address)

15. Filed May 12, 1930 E E Ing. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7, 1930, to May 10, 1930, that I last saw him alive on May 10, 1930, and that death occurred, on the date stated above, at 4 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Rocky Mountain Spotted Fever

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Toxic myocarditis

(duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? Yaak Montana

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) R M Bowell, M. D.

May 12, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Sandpoint, Ida.	19

20. Undertaker	Address
A. R. Crouch	Bonners Ferry, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73139

PLACE OF DEATH
County of Boundry
City of Bonners Ferry

Registration District No. 71
Primary Registration District No. 1156
Local Registrar's No. 88 b
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Van Howard
(a) Residence. No. 1421 N. Maxwell St. Spokane Washington
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Claudia Stafford

6. DATE OF BIRTH (month, day and year) July 28 = 1880

7. AGE Years 49 Months 10 Days 6 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER S. C. Howard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Hanna Johns
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio

14. Informant (Address) Mrs. Claudia Howard, Spokane Washington

15. Filed May 4th 1930. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on May 4th, 1930
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Spokane, Wn
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Thyroid Examination
(Signed) [signature], M. D.
5/4, 1930 (Address) Bonners Ferry, Id

19. Place of ~~Burial, Cremation, or~~ Removal Spokane Washington
Date of Burial 19

20. Undertaker H. R. Crouch
Address Bonners Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73140

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74 a

2. FULL NAME Edward Thomas.
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Phoebe Thomas
6. DATE OF BIRTH (month, day and year) May. 2-1866
7. AGE Years 64 Months Days 1 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER Webb Thomas.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Morgan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn.

14. Informant (Address) R. M. Thomas. Bonners Ferry, Ida
15. Filed May 4th, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 W. (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1929, to May 3, 1930
that I last saw him alive on May 3 W. 1930
and that death occurred, on the date stated above, at 4.45 A.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) arteriosclerosis - hypertension
(duration) yrs. 6 mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Physical examination
(Signed) [signature], M. D.
5/4/ 1930 (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal Bonners Ferry, Ida
Date of Burial May 6 - 1930
20. Undertaker [signature]
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7314

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

89

2. FULL NAME Joseph Francis Ertz,

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Ertz

6. DATE OF BIRTH (month, day and year): Oct. 10, 1882

7. AGE: Years 47, Months 7, Days 24. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Spokane International Ry. Co.

9. BIRTHPLACE (city or town) (State or country): Rockford, Ill.

PARENTS

10. NAME OF FATHER: Joseph Ertz
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Mary Burkhart
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ill.

14. Informant (Address): Mrs. Bertha Ertz, Bonners Ferry, Ida.

15. Filed June 4, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3, 1930, (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3:50P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Sudden death)

..... (duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Ken Bowell Coroner, M. D.
June 4, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida.
Date of Burial: June 6, 30

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 30 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73142

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88 V

2. **FULL NAME** Mary Pernot

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 3. 1857.

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
73	4		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ontario Canada.

PARENTS

10. NAME OF FATHER Patrick Judge
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown.

14. Informant (Address) Ed. Burkholder, Moyie Springs, Ida.

15. Filed June 3rd 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 2, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocardial degeneration
(Found dead in bed)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) [signature] M. D.
June 3, 1930 (Address) Bonners Ferry Ida Coroner

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida.
Date of Burial: June 4, 1930

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida.
Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73143

PLACE OF DEATH

County of Boundary. Registration District No. 79

City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No.

(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Ellen Powell

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White.	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 15 - 1856

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	7	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Larkins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Lewis Powell
(Address) Lexington, Neb.

15. Filed 3/17, 1930. E E Fay Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 16 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1930, to Mar. 16, 1930
that I last saw h[illegible] alive on Mar. 16, 1930
and that death occurred, on the date stated above, at 11. A m.

The CAUSE OF DEATH* was as follows:
Senile dementia.
Malnutrition.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Colitis.

(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis?

(Signed) E E Fay, M. D.
3/17, 1930 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Lexington, Neb.	

20. Undertaker	Address
H. P. Crouch	Bonners Ferry Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED DEC 26 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73144

PLACE OF DEATH

County of Boundary Registration District No. 79

City of Bonners Ferry Primary Registration District No. 9136

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Eli Takala

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 21-1882

7. AGE — Years: 47 | Months: 10 | Days: 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Finland

14. Informant: Mr. Rupatti
(Address) Copeland Idaho

15. Filed Dec. 31, 1930. E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Rud Sowrde M. D.

Feb 25, 1930 (Address) Bonners Ferry Idaho Coroner

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry	Mar. 1 1930
20. Undertaker	Address
H. R. Crouch	Bonners Ferry.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73145

PLACE OF DEATH

County of Boundary Registration District No. 99
City of Bonners Ferry Primary Registration District No. 2154 Local Registrar's No.
(No.) 118 P
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Elizabeth Maloney

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 17 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bonners Ferry

PARENTS

10. NAME OF FATHER John Maloney

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Dak.

12. MAIDEN NAME OF MOTHER Alma Taylor

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ontario.

14. Informant John Maloney
(Address) Bonners Ferry,

15. Filed Feb. 17, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 17 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw her alive on Feb. 17, 1930.
and that death occurred, on the date stated above, at 5:15 A. m.
The CAUSE OF DEATH* was as follows:

Colitis
Obstruction of bowel (ileum)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis diverticulum
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes.
What test confirmed diagnosis? autopsy.

(Signed) E. E. Fry, M. D.
2/17/1930 (Address) Bonners Ferry, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry.	Feb. 19 1930
20. Undertaker	Address
H. P. Crouch	Bonners Ferry.

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73146

PLACE OF DEATH
County of Boundary
City of Bonners Ferry.

Registration District No. 29
Primary Registration District No. 2154

Local Registrar's No.

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Tildon Wright

(a) Residence. No. ..... St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 6 - 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72.	6	10	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Minnesota.

PARENTS

10. NAME OF FATHER: Wm. Wright.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois.
12. MAIDEN NAME OF MOTHER: Mary Tildon.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio.

14. Informant: Mrs. Mary Stephens.
(Address): Burlington Wash.

15. Filed Feb. 17 - 1931. E E Fox Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Feb 16, 1930
that I last saw him alive on Jan 21, 1930
and that death occurred, on the date stated above, at 12:20 A m.

The CAUSE OF DEATH* was as follows:
Chronic Myocardial degeneration
.....
.....
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No Physical Examination
What test confirmed diagnosis? .....
(Signed) R. M. Bovee, M. D.
Feb 17, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Paradise Valley Cemetery, Bonners Ferry	Feb 18 1930
20. Undertaker: H P. Crouch	Address: Bonners Ferry.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73147

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

70

2. **FULL NAME** Abraham Molouf

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE:
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Unknown 1903

7. AGE: Years 27 | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Railroad Construction
(c) Name of employer: Morrison - Knudson Co.

9. BIRTHPLACE (city or town) (State or country): Assyria

PARENTS

10. NAME OF FATHER: R. Molouf
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Assyria
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Assyria

14. Informant (Address): R. Molouf, Saskatoon, Canada

15. Filed 4/25/, 1930. E. E. Frey Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 24, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 31st, 1930, to Apr. 24th, 1930.
that I last saw him alive on April 24th, 1930
and that death occurred, on the date stated above, at 2 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Compound Fracture of skull
(Falling rock accidental)
Encephalitis.
(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Yakt, Mont.
Did an operation precede death? no. Date of
Was there an autopsy? no.
What test confirmed diagnosis? Physical Exam. + History
(Signed) E. E. Frey, M. D.
4/25/, 1930. (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida,
Date of Burial: Apr. 29 1930

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida.
Address

RECEIVED DEC 8 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 13148

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Gladys Leslie

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F.	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Keith Leslie

6. DATE OF BIRTH (month, day and year) Mar. 14, 1917

7. AGE	Years	Months	Days	If LESS than 1 day,
	17	1	8	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER L.C. Beck

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Lillian Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant L.C. Beck,
(Address) Bonners Ferry, Ida.

15. Filed 4/23/ 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21st. 1930, to Apr. 22 nd. 1930
that I last saw her alive on Apr. 22 nd. 1930
and that death occurred, on the date stated above, at 11 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Childbirth

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Widal.

(Signed) E E Fry, M. D.
4/23/ 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Apr. 24, 1930
20. Undertaker	Address
H.R. Crouch.	Bonners Ferry.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73149

PLACE OF DEATH
County of Boundary
City of Bonners Fy.

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

146

2. FULL NAME Cora May Secrist

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of C.A. Secrist

6. DATE OF BIRTH (month, day and year) Mar. 12, 1900

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	1	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Montana

PARENTS

10. NAME OF FATHER J.W. Ellis,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Emma Steinbrink
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant (Address) C.A. Secrist, Bonners Ferry, Ida.

15. Filed 4/22/, 1930. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 21, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13th 1930, to Apr. 21st, 1930.
that I last saw her alive on , 19
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Septic Peritonitis.

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Septic abortion
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? History
(Signed) [signature], M. D.
4/22/, 1930. (Address) Bonners Ferry, Ida.

19. Place of Burial, Cremation, or Removal Bonners Ferry, Ida.
Date of Burial April 24 1930

20. Undertaker H.R. Crouch, Bonners Ferry, Ida.
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73150

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. 8
(No. Bonners Ferry Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Thelma Carlson.

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Carlson

6. DATE OF BIRTH (month, day and year) March 14-1909

7. AGE Years 21 Months 1 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Ketcham.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Lizzie Fletcher
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Carl Carlson Bonners Ferry Ida

15. Filed 4/21/30 19..... E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 13 1930, to Apr. 20, 1930
that I last saw her alive on Apr. 20th 1930
and that death occurred, on the date stated above, at 4 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Scarlet Fever

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Childbirth

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Physical Exam. Hist.
(Signed) E E Fry, M. D.
4/21/, 1930 (Address) .....

19. Place of Burial, Cremation, or Removal Bonners Ferry Ida
Date of Burial Apr 22 1930

20. Undertaker H. R. Crouch, Bonners Ferry
Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7315

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. **FULL NAME** Mary M. White,

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 27, 1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	2	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Redwing
(State or country) Minn.

PARENTS

10. NAME OF FATHER Charles Holbrook

11. BIRTHPLACE OF FATHER (city or town) New York
(State or Country)

12. MAIDEN NAME OF MOTHER Matilda Muir

13. BIRTHPLACE OF MOTHER (city or town) New York
(State or County)

14. Informant Frank White,
(Address) Bonners Ferry, Ida.

15. Filed 4/15/, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1930, to Apr. 14 - 1930
that I last saw h.. alive on Apr. 14 - 1930
and that death occurred, on the date stated above, at 6:15P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of the right Kidney

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? Yes.
What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.
4/15/, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Elsworth, Minn.	

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7315?

REC... DEC 9 1930

PLACE OF DEATH

County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

884

2. **FULL NAME** Elizabeth Ann Causton

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 38 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of I. Causton

6. DATE OF BIRTH (month, day and year) Nov. 1, 1851

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER William Brentall

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales

12. MAIDEN NAME OF MOTHER Elizabeth Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) I. Causton Bonners Ferry, Ida.

15. Filed 4/13/, 1930. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Apr. 12 - 1930
that I last saw h... alive on Apr. 12 - 1930
and that death occurred, on the date stated above, at 1:45 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
myocardial degeneration -

(duration) ...yrs. 1 mos. ...ds.
CONTRIBUTORY (Secondary) Bronchitis
(duration) ...yrs. 2 mos. ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No. What test confirmed diagnosis? Physical Exam.

(Signed) ..., M. D.
4/13/, 1930 (Address) Bonners Ferry, Ida.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. Date of Burial: Apr. 15, 1930

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73153

PLACE OF DEATH

County of Boundary
City of Bonners Ferry
Registration District No. 79
Primary Registration District No. 2156
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

57

2. FULL NAME Pauline Schauer,

(a) Residence. No. Naples, Idaho. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 13, 1922.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	9	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Springdale, Wash.
(State or country)

PARENTS
10. NAME OF FATHER Charles Schauer
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Mary Boerner
13. BIRTHPLACE OF MOTHER (city or town) Wisconsin
(State or Country)

14. Informant Charles Schauer
(Address) Naples, Idaho.

15. Filed 4/12/ 1930. E E Fay Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4 1930, to Apr. 11 1930
that I last saw h[illegible] alive on Apr. 11 th. 1930
and that death occurred, on the date stated above, at 3: P.M. m.
The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Naples, Idaho.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination of urine -
(Signed) E E Fay, M. D.
4/12/ 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Apr. 14, 30.

20. Undertaker — Address
H.R. Crouch, Bonners Ferry, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73154

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No. Bonners Ferry Hospital

(If death occurred in a hospital or institution, give its name instead of street and number.)

74 a

2. FULL NAME Joseph H. Heinen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Unknown

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Unknown

7. AGE Years 60 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED Confectionery stand owner.

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Hospital Records

(Address) Bonners Ferry, Ida

15. Filed Apr. 8, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec., 1929, to Apr. 6th, 1930, that I last saw him alive on Apr. 5, 1930 and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. E. Fry, M. D.

Apr. 8, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Fosholm, N. Dak. Date of Burial 19

20. Undertaker H. R. Crouch, Bonners Ferry, Ida. Address

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73155

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129

Local Registrar's No. 36

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Otis Byron Cain

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Alma Cain

6. DATE OF BIRTH (month, day and year) Dec. 1, 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	0	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Robert Dietrich

9. BIRTHPLACE (city or town) (State or country) Augusta, Maine

PARENTS

10. NAME OF FATHER Mr. Cain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Guy R. Cain
(Address) Colorado.

15. Filed Dec. 24, 1930 T. C. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on Dec 23 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Accidental
Freezing to death
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. R. Egbert, M. D.
Dec 24, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Arco, Idaho.	Dec. 25 1930

20. Undertaker	Address
Gladys Grimes	Arco, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

REC'D JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. ~~35~~ 73156

PLACE OF DEATH
County of Butte
City of Moore
Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 35
(No.) 164 Senility
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Jane Harris
(a) Residence. No. ... St. ...
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 10 yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Johnathon M. Harris

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	5		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Noble Co. Ohio

PARENTS

10. NAME OF FATHER Thos. Farson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) County Cork Ireland
12. MAIDEN NAME OF MOTHER Easter Farson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Thos. A. Harris
(Address)

15. Filed Dec. 20, 1930 J. C. Salt Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 16, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Due to old age
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? ...
Did an operation precede death? ... Date of ...
Was there an autopsy? No
What test confirmed diagnosis? 83 years
(Signed) Edna Gardner Coroner M. D.
Dec. 17, 1930 (Address) Arco Idaho

19. Place of Burial, Cremation, or Removal Lost River Cemetery — Date of Burial Dec 20 1930
20. Undertaker Lydia Garnier — Address Arco, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 731

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Butte
City of Arco
Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 34
(No. 14a)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Agnes Fleischer
(a) Residence. No. Arco St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 24 yrs. mos. ds. How long in U. S. if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Otto B. Fleischer

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant (Address) Otto B. Fleischer Arco Idaho

15. Filed Dec. 3, 1930 T. Balb Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25, 1930, to Dec 1, 1930
that I last saw her alive on Nov. 30, 1930
and that death occurred, on the date stated above, at 1:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical exam
(Signed) L. M. Egbert M. D.
Dec 1, 1930 (Address) Arco Ida.

19. Place of Burial, Cremation, or Removal Arco, Idaho — Date of Burial Dec. 3 193

20. Undertaker Gladys Garner — Address Arco, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN [illegible] 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73155

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129 Local Registrar's No. 33
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

11a

2. FULL NAME Earl Eugene Parris

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 22-1910

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20		28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Lost River S. Dakota

PARENTS

10. NAME OF FATHER James D Parris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Lucinda Lyle
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo.

14. Informant Mrs Juanita M Miller
(Address)

15. Filed Nov. 28, 1930 W. H. Hall Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1930, to Nov. 20, 1930
that I last saw him alive on Nov. 20, 1930
and that death occurred, on the date stated above, at 2:00 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia
(duration) yrs. mos. 8 ds.

CONTRIBUTORY .....
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Thought Exam

(Signed) H. E. Eyestone, M. D.
Nov. 24, 1930 (Address) Arco Ida.

19. Place of Burial, Cremation, or Removal: Arco Cemetery — Date of Burial: Nov. 21 1930
20. Undertaker: [illegible] — Address: [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73159

PLACE OF DEATH
County of Butte
City of Arco

Registration District No. 59
Primary Registration District No. 2129
Local Registrar's No. 32
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88b

2. FULL NAME Antone Vaso
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Vaso
6. DATE OF BIRTH (month, day and year) Unknown
7. AGE Years 94 Months Approx Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS
10. NAME OF FATHER Mr Vaso
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant George Walker
(Address) Arco Ida

15. Filed Nov. 8, 1930 T. C. Ball Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 5 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Nov. 5, 1930
that I last saw him alive on Nov. 5, 1930
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:
Cardiac insufficiency
..... (duration) ..... yrs. ..... mos. 4 ds.
CONTRIBUTORY (Secondary) Myocarditis
..... (duration) 10 yrs. ..... mos. ~~4~~ ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Physical exam
(Signed) J. R. Egbert, M. D.
Nov. 6, 1930 (Address) Arco Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal To Boise, Idaho
Date of Burial Nov. 9, 1930
20. Undertaker V. F. McHan
Address Idaho Falls

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73[illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Camas
City of Fairfield

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

58 b

2. FULL NAME Minnie Phyllis Yagnich

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Steve Yagnich

6 DATE OF BIRTH (month, day and year): Jan. 17-1905

7 AGE: Years 25 | Months 1 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Grade
(c) Name of employer: Soldier School

9 BIRTHPLACE (city or town) (State or country): Soldier, Idaho

PARENTS
10 NAME OF FATHER: James M Williams
11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia City, Mont.
12 MAIDEN NAME OF MOTHER: Francis Battle
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster Wisconsin

14 Informant: J. M. Williams Jr.
(Address): Salt Lake City Utah.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March (Month) 9 (Day) — 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1929, to Mar. 9, 1930, that I last saw her alive on Mar. 9, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows: Anemia following membranous Dimenophlea.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Haemaphillia
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Feb. 23-30
Was there an autopsy? no
What test confirmed diagnosis? Clinical Symptoms
(Signed) A. S. Sheets, M. D.
Mar. 12, 1930 (Address) Fairfield Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Soldier Cemetery | Date of Burial: Mar. 11-30

20. Undertaker: Earnest McHan | Address: Fairfield Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-25 M. 1-19.

RECEIVED DEC 24 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13165

Registered No.

1. PLACE OF DEATH

County of Camas Near

City of Fairfield

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Relf J. Bledsoe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: August (Month) 20th (Day) 1863 (Year)

7. AGE: 67 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Walla Walla Wash.

10. NAME OF FATHER: Relf Bledsoe

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Helen Kinney

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm J. Northrop

(Address) 925 N. 5. Ave Boise Idaho

15. Filed Nov 8 1930 Alice Turner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

74 a

16. DATE OF DEATH: Nov (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-7 1930 to 11-7 1930 that I last saw h-m alive on 11-7 1930 and that death occurred on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Head injury / Auto accident

(Duration) ..... yrs. 14 mos. 14 ds.

(Signed) Houston E Snyder M. D.

11-19 1930 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Solcher Cemetery Fairfield Ida

DATE OF BURIAL: Nov 9 1930

20. UNDERTAKER: McHan Bdw 6

ADDRESS: Fairfield Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5.35 M. 1-19. RECEIVED DEC 24 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Camas Co

City of Fairfield

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 13162

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME X Ellen Fairbanks Silvers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 22 (Day) 1859 (Year)

7. AGE: 71 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Zanesville Iowa

10. NAME OF FATHER: James Fairbanks

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Liza Williams

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. E. Painter.

(Address) Fairfield Ida.

15. Filed Dec. 1 1930 Alice Turner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH X 44

~~Nov~~ Dec (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1930, to Nov 12 1930 that I last saw her alive on Nov 12 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(Duration) X ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) — — — —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Houston E. Snyder M. D.

12-1 1930 (Address) Loading

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldier Cemetery

DATE OF BURIAL: Dec 3 1930

20. UNDERTAKER: Earnest McHan

ADDRESS: Fairfield Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73163

PLACE OF DEATH

County of Camas
City of Fairfield

CERTIFICATE OF DEATH

Registration District No. 58
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Albert Thomas Leek 204
(a) Residence. No. Fairfield Ida St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie Leek

6. DATE OF BIRTH (month, day and year) Dec 28, 1858

7. AGE 71 Years | Months 10 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pensylvania

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wales

14. Informant (Address) Mrs Nellie Leek Fairfield Ida

15. Filed Nov 14, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 ..... 19 ..... was dead when I saw him
that I last saw him ..... 19 .....
and that death occurred, on the date stated above, at 9 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. W. Hamer, M. D.
..... 19 ..... (Address) .....

19. Place of Burial, Cremation, or Removal: Boise Idaho | Date of Burial: Nov 16 1930

20. Undertaker: H. L. McHan | Address: Pocatello

RECEIVED JAN 12 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73170

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

Local Registrar's No. 152

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

884

2. **FULL NAME** John Gianola

(a) Residence. No. 1003 Blaine St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 13 - 1852

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
78	5	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (city or town) (State or County) " "

14. Informant (Address) John A Baker 1003 Blaine Caldwell Ida

15. Filed 12-11-, 1930. John L Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 8-, 1930 that I last saw him alive on Dec 6, 1930 and that death occurred, on the date stated above, at 1:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis -
Previous Cause T. B.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) age - Arteriosclerosis

(duration) ... yrs. 4 mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) L D Foster, M. D.
Dec 9, 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill.	12-10 1930
20. Undertaker C. V. Peckham	Address Caldwell Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 12 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73171

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Wilder

Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 153
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

197

2. **FULL NAME** John Henry Amend

(a) Residence. No. Wilder; Ida St.
(Usual place of abode.)
(If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 7 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	11	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kane Wyo.

PARENTS

10. NAME OF FATHER J. E. Amend

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Russia

12. MAIDEN NAME OF MOTHER Marie Etta Hoffman

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Nebraska

14. Informant (Address) Rufus Burke Homedale Ida

15. Filed 12-12-, 1930 John S. Meyers Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Dec 10, 1930
that I last saw him alive on Dec 10, 1930
and that death occurred, on the date stated above, at 12:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Homicidal by firearm - 38 Cal automatic wound thru Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Internal Hemmorrhage

(duration) yrs. mos. 35 min.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) Robert E Talbot, M. D.
Dec 10, 1930 (Address) Wilder

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohler Lawn	12-12-1930
20. Undertaker C. V. Peckham	Address Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73172

PLACE OF DEATH
County of Canyon
City of Caldwell
Registration District No. 3
Primary Registration District No. 2005
Local Registrar's No. 154
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Ruben Daniel
(a) Residence. No. Wilder Ida St. 197
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan 25 1907
7. AGE Years 23 Months 10 Days 15 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ranching
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS
10. NAME OF FATHER R. A. Daniel
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Lenora Simpson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Illinois

14. Informant (Address) R. A. Daniel Wilder
15. Filed 12-12-, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 10 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1930, to Dec 10, 1930
that I last saw him alive on Dec 10, 1930
and that death occurred, on the date stated above, at 7 P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Gun shot wound through the pelvis, wound receiving while he was attempting to hold up a restaurant at Wilder Idaho (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? Wilder, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms
(Signed) [signature], M. D.
12/11, 1930 (Address) Caldwell Idaho

19. Place of Burial, Cremation, or Removal Canyon Hill
Date of Burial 12/13 1930
20. Undertaker C. V. Peckham
Address Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73173

PLACE OF DEATH
County of Camyon
City of Caldwell

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 155
(No. Caldwell Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Rosa M. Tremewan 140
(a) Residence. No. R F D Caldwell Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of C.S. Tremewan

6. DATE OF BIRTH (month, day and year) Feb 3 1882

7. AGE Years 48 Months 10 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Skelton Nevada

PARENTS
10. NAME OF FATHER Oliver Riffe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Sarah White
13. BIRTHPLACE OF MOTHER (city or town) (State or County) West Virginia

14. Informant (Address) C. S. Tremewan R. 2 Caldwell Idaho

15. Filed 12-15, 1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 14 1930, 19..
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1, 1929, to December 14, 1930
that I last saw her alive on December 13 1930
and that death occurred, on the date stated above, at 7 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Menorrhagia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fibro Myomata Uterus
(duration) 7 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec. 9-1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Exploratory
(Signed) S. B. Dudley M. D.
Dec 15 1930 (Address) Caldwell Ida

19. Place of Burial, Cremation, or Removal Elko Nevada Date of Burial Dec 17-30 19

20. Undertaker Paul L. Case Address Caldwell Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

15

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73174

PLACE OF DEATH

County of Canyon
City of Middleton

CERTIFICATE OF DEATH

Registration District No. 3
Primary Registration District No. 2005 Local Registrar's No. 156
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Sarah Angeline Endecott 128
(a) Residence. No. Middleton St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of J. J. Endicott

6. DATE OF BIRTH (month, day and year) Oct 19 - 1860

7. AGE Years 70 Months 1 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hardin Co. Iowa

PARENTS

10. NAME OF FATHER Jacob Kris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indianna
12. MAIDEN NAME OF MOTHER Emaline Dawson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ind.

14. Informant (Address) J. J. Endcott Middleton, Ida

15. Filed 12-23, 1930. John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1930, to Dec. 18, 1930
that I last saw her alive on Dec 18, 1930
and that death occurred, on the date stated above, at 7:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows Intestinal Influenza
(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Nephritis
(duration) yrs. mos. unknown ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis Chemical
(Signed) M Kaley, M. D.
12-20, 1930 (Address) Caldwell Ida
c of God 2-

19. Place of Burial, Cremation, or Removal Middleton
Date of Burial Dec 20 1930

20. Undertaker C. V. Peckham
Address Caldwell, Ida

STATE OF IDAHO

RECEIVED JAN 13 1931 DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73175

PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005 Local Registrar's No. 158

(No. 1019)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Betty Lucile Fillmore

(a) Residence. No. 1019 Caldwell, Ida. R#3 St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of S. A. Fillmore

6. DATE OF BIRTH (month, day and year) June 29-1923

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
7	6		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Caldwell Idaho.

PARENTS

10. NAME OF FATHER S. A. Fillmore

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Baker.

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kansas

14. Informant S. A. Fillmore (Address) RD#3-

15. Filed 12-31-1930 John S. Meyer Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 23 1930 to Dec. 29 1930, that I last saw her alive on Dec. 27 1930, and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Dilation of Heart

(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. W. Whittenburger M. D.

Dec 30 1930 (Address) Caldwell, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Canyon Hill	12-31 1930
20. Undertaker C. W. Peckham	Address Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73176

PLACE OF DEATH

County of Canyon
City of Nampa
Registration District No. 7
Primary Registration District No. 1006
(No.) Mercy Hospital
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 57

RECEIVED JAN 9 1931

2. FULL NAME Aurelia Anna Phillips

(a) Residence. No. ~~No.~~ Mc Call ~~Idaho~~ ~~St.~~
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of V. E. Phillips

6. DATE OF BIRTH (month, day and year) Aug 24 - 1911

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19	2	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Allan Shire
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Hazel Jenkins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant V. E. Phillips
(Address) Mc Call Ida

15. Filed 12-5, 1930 Letha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 23rd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 29th, 1930, to Nov. 23rd, 1930, that I saw h~~er~~ alive on Nov. 23rd, 1930, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:
General peritonitis.
(duration) 0 yrs. 0 mos. 4 ds.
CONTRIBUTORY (Secondary) gangrenous appendicitis and abcess. (duration) 0 yrs. 1 mos. 25 ds.

18. Where was disease contracted if not at place of death? Mc Call, Idaho.
Did an operation precede death? yes Date of 11/25/30.
Was there an autopsy? No.
What test confirmed diagnosis? Operation.
(Signed) Jno. Partridge, M. D.
12/5, 1930 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerlawn Cem	11-25-1930
20. Undertaker	Address
Fred K. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73177

Local Registrar's No. 138

RECEIVED JAN 9 1931

PLACE OF DEATH

County of Canyon
City of Nampa.
Registration District No. 7
Primary Registration District No. 1006
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Davis Mckee.

(a) Residence. No. 1012-10th. Ave.S. St. 100 a
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 18, 1845.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	5	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bolivar, Pa.

PARENTS

10. NAME OF FATHER Robert Mckee
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pa.
12. MAIDEN NAME OF MOTHER Sarah Mccray
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pa.

14. Informant Mrs Wesly Bone
(Address) Nampa Idaho

15. Filed 12/5, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 2, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from 11-26, 1930, to 12-1, 1930
that I last saw her alive on 12-1, 1930
and that death occurred, on the date stated above, at 1.15 A m.
The CAUSE OF DEATH* was as follows:

Bronchi Pneumonia.

(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Senility.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —

(Signed) J E Hawkins M. D.
12-5, 1930 (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosedale Cem.	12/5/30 19
20. Undertaker	Address
F. H. Robinson.	Nampa Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7317

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 2006
Local Registrar's No. 39
(No. 2 mi. so. East Nampa)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Genevieve Grace Janoushek
(a) Residence. No. 128 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Adolph Janoushek

6. DATE OF BIRTH (month, day and year) May 6th 1911

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	7	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indian Valley Idaho

PARENTS
10. NAME OF FATHER Frank Moore
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Austin Texas
12. MAIDEN NAME OF MOTHER Grace Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Colo. Spgs Colorado

14. Informant (Address) Mrs. Frank Moore Nampa Ida.

15. Filed 12/8, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 6th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1930, to Dec 6, 1930
that I last saw him alive on Dec 5th, 1930
and that death occurred, on the date stated above, at 5 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
Complicating scarlet
fever
(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) F. C. Byington M. D.
Dec 8, 1930. (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa — Date of Burial: 12-7 1930
20. Undertaker: Mrs. Nina M. Talley — Address: Nampa, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73170

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006
(No. 816 - 2nd Street No)
Local Registrar's No. 140

(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 9 1931

2. FULL NAME Mary Anna Dowdle 88 St.
(a) Residence. No. 816 - 2 Str. No.
(Usual place of abode.)
(If nonresident give city or town and State.)
Length of residence in city or town where death occured yrs. 2 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. ~~If married,~~ widowed, or divorced
~~HUSBAND~~ of (or) WIFE of John C Dowdle

6. DATE OF BIRTH (month, day and year) April 16 - 1847

7. AGE Years 83 Months 9 Days 22. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England.

PARENTS
10. NAME OF FATHER Samuel Chandler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England.
12. MAIDEN NAME OF MOTHER Mary Jarvise
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant (Address) W. J. Dowdle.

15. Filed 1-2, 1930 Bertha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 30 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10, 1930, to Dec 30, 1930
that I last saw her alive on Dec 29, 1930
and that death occurred, on the date stated above, at 12 noon.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Paralysis below waist
Myocarditis and organic
heart mitral valve.
Acute dilitation heart (duration) yrs. 1 mos. 1 ds.
CONTRIBUTORY (Secondary) Acute dilitation and
above (duration) 2 yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Horace P. Kilhuff M. D
12/31, 1930 (Address) Nampa Ida.

19. Place of Burial, Cremation, or Removal Williard, Utah
Date of Burial 1-2 1930
20. Undertaker Mrs. Nina M. Talley
Address Nampa Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73180

Registration District No. 7
Primary Registration District No. 1006
Local Registrar's No. 141

PLACE OF DEATH
County of Canyon
City of Nampa
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 9 1931

2. FULL NAME Elizabeth L. Harris

(a) Residence. No. 212-19 ave S St. 179
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 18, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10. NAME OF FATHER Thos. M. Patrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va
12. MAIDEN NAME OF MOTHER Celia Anne Patrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Va

14. Informant Sarah Harris
(Address) Nampa Ida

15. Filed 1-2, 1931 Bertha Conaway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30, 1930, to Dec, 1930
that I last saw her alive on Dec 30, 1930
and that death occurred, on the date stated above, at 2 a m.
The CAUSE OF DEATH* was as follows:
Uremic Coma
(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) Chronic Nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ~
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) C C Kellam M. D.
Jan 2, 1931 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Kohlenlawn Cem.	
20. Undertaker	Address
F. K. Robinson	Nampa Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73181

PLACE OF DEATH
County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1026
Local Registrar's No. 142
(No.) Mercy Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 9 1931

2. FULL NAME Evelyn Reeta Gregory

(a) Residence. No. 215 - 23 ave S St. Nampa
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 24 - 1908

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	11		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Okla.

PARENTS

10. NAME OF FATHER Chas. Rars
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Okla
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Okla

14. Informant Louis Gregory
(Address) Nampa Idaho.

15. Filed 1/3, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 - 1930 to Dec. 31, 1930
that I last saw h alive on Dec. 31, 1930
and that death occurred, on the date stated above, at 10 15 m.
The CAUSE OF DEATH* was as follows:
Coronar embolus
(duration) yrs. mos. 1 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec. 31-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) Sammel A Swanson M.D.
Jan. 3 - 1931 (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kohlerdam Cem	1 - 4 1931
20. Undertaker F. K. Robinson	Address Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73182

PLACE OF DEATH
County of Canyon.
City of Nampa.

Registration District No. 7
Primary Registration District No. 1006
(No. Mercy Hosp't.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 145

RECEIVED JAN 9 1931

2. FULL NAME Charles Francis Rogers.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) May 7, 1909

7. AGE: 21 Years, Months: 7, Days: 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Silver City, Ida.

PARENTS

10. NAME OF FATHER: Charles A. Rogers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.
12. MAIDEN NAME OF MOTHER: Celia May McMahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Silver City. Ida.

14. Informant: Elizabeth Drallinger.
(Address) Murpley Ida.

15. Filed 12-10, 1930 Bertha Conway Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 8 (Day) 1930. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec., 4th, 1930, to Dec., 8th, 1930
that I last saw him alive on Dec., 8th, 1930
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:
Pyaemia.
(duration) 0 yrs. 0 mos. 10 ds.
CONTRIBUTORY (Secondary) Endocarditis and nephritis.
(duration) 0 yrs. 6 mos. 0 ds.

18. Where was disease contracted if not at place of death? Silver City, Idaho.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Multiple abscesses.
(Signed) Geo. O. A. Kelly Jr., M. D.
12-10-, 1930. (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St. John's Cemetery Boise Idaho
Date of Burial: 12/11 1930

20. Undertaker: Schreiber and McCann
Address: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73183

PLACE OF DEATH

County of Canyon
City of Nampa

CERTIFICATE OF DEATH

Registration District No. 7
Primary Registration District No. 1006
(No. Samaritan Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No. 144

2. **FULL NAME** Bessie Mabel Hatfield

(a) Residence. No. 6 mi. no. east Nampa St.
(Usual place of abode.)
Length of residence in city or town where death occured 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

RECEIVED JAN 9 19[illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Don Hatfield

6. DATE OF BIRTH (month, day and year) January 16th 1887

7. AGE: Years 43, Months 11, Days 15. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Amos Sniders
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Sarah J. Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Ohio

14. Informant (Address): Don Hatfield, Nampa, Idaho

15. Filed 1-3, 1931 Seth Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 8, 1930, to Dec. 31, 1930
that I last saw her alive on Dec 31, 1930
and that death occurred, on the date stated above, at 11:45 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Spinal Meningitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) W C Wolf M.D., M. D.
1-3, 1931 (Address) Nampa, Ida.

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa
Date of Burial: 1-3 1931

20. Undertaker: Mrs Nina M. Talley
Address: Nampa, Id.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7318

PLACE OF DEATH
County of Canyon
City of Nampa.

Registration District No. 7
Primary Registration District No. 2006
(No. Nampa, Idaho R. #5.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 145

JAN 9 1931

2. **FULL NAME** Mrs. Fannah Plant.

(a) Residence. No. Nampa, Idaho. R.#5. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 26 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female.	White.	Divorced.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward L. Plant.

6. DATE OF BIRTH (month, day and year) October 28th 1854

7. AGE Years	Months	Days	If LESS than 1 day, ---hrs. or ---min.
76	2	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sheffield, England.

PARENTS

10. NAME OF FATHER William Rawlin.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Eangland.
12. MAIDEN NAME OF MOTHER Caroline Wilde.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England.

14. Informant Mrs. T. J/ Andrews.
(Address) Nampa, Idaho.

15. Filed 1/7, 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 31st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7-'30 19..., to Dec. 31- 19 30
that I last saw her alive on Dec. 30 19 30
and that death occurred, on the date stated above, at 5:50 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Samuel A. Lindsay M. D.
Jan 2, 1931 (Address) Nampa, Idaho.

19. Place of Burial, Cremation, or Removal: Morris Hill Cemetery. Date of Burial: 1/2/31 19

20. Undertaker: Wm. McBratney. Address: Boise, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73185

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Canyon
City of Nampa

Registration District No. 7
Primary Registration District No. 1006 57 Local Registrar's No. 146
(No. 207-9th Ave. So.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 9 1931

2. FULL NAME Lidy Catherine Oliver
(a) Residence. No. 207-9th Ave. So. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 16 yrs. 3 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Wiley H. Oliver

6. DATE OF BIRTH (month, day and year): Oct. 15th 1871

7. AGE: Years 59 | Months 2 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Jackson Co. Missouri

PARENTS

10. NAME OF FATHER: Thomas J. Richards
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Martha J. Lovelace
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Cotter Co. Tennessee

14. Informant (Address): Mrs. Esther Bennett Nampa, Idaho

15. Filed 1-4, 1931 Seitha Conway Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 31, 1930
that I last saw her alive on Dec. 31 1930
and that death occurred, on the date stated above, at 7 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetes — 16 yrs
Chronic Interstitial nephritis two years.
Died of uremia
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) Geo. P. Proctor M. D.
Jan. 3, 1931 (Address) Nampa Idaho

19. Place of Burial, Cremation, or Removal: Kohlerlawn-Nampa | Date of Burial: 1-4 1931

20. Undertaker: Mrs. Nina M. Talley | Address: Nampa, Id.

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73186

PLACE OF DEATH

County of Canyon
City of Parma
Registration District No. 3
Primary Registration District No. 2007
Local Registrar's No. 19
(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Layton Rucker

(a) Residence. No. Parma St. Ida
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Amanda M Rucker

6. DATE OF BIRTH (month, day and year) May 24 1843

7. AGE: Years 87 | Months 7 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Summerfield Ohio

PARENTS

10. NAME OF FATHER Ismael Rucker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia
12. MAIDEN NAME OF MOTHER Lucy Blake
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine

14. Informant Amanda M. Rucker
(Address) Parma Ida

15. Filed Dec 1, 1930 Ruby Waldrop Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13, 1930, to Dec 28, 1930
that I last saw h— alive on Dec 28, 1930
and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No.
What test confirmed diagnosis? Symptoms

(Signed) L M. Rucker, M. D.
12-30, 1930 (Address) Parma Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Parma Cem	12-29-30
20. Undertaker C. V. Peckham	Address Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73187

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 35

2. FULL NAME Peter Lorgan Norstrom 74a
(a) Residence. No. Soda Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Widower Annettie Sophia Norstrom

6. DATE OF BIRTH (month, day and year) Oct. 17-1873

7. AGE Years 57 Months 2 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Fairview Utah

PARENTS
10. NAME OF FATHER Peter Norstrom
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Josephene Van Valkenburg
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salt Lake City Utah

14. Informant Ined N. Fryar
(Address) Soda Springs Idaho

15. Filed 12-27, 1930 Dr. Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1930, to Dec 27, 1930
that I last saw her alive on Dec 27, 1930
and that death occurred, on the date stated above, at 3:30 a m.
The CAUSE OF DEATH* was as follows:
Cerberal Hemorrhage
..... (duration) ..... yrs. ..... mos. 1 minute ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? 0 Date of .....
Was there an autopsy? 0
What test confirmed diagnosis? None
(Signed) Ellis Kaus Fry, M. D.
12-27-1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Soda Springs Idaho — Date of Burial Dec 30, 1930

20. Undertaker E D Whitman — Address Soda Springs Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 3 1931

PLACE OF DEATH

County of Caribou

City of Soda Springs

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 82

Primary Registration District No. 2159

(No. 749)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 73188

Local Registrar's No. 34

2. FULL NAME Frances L Newman

(a) Residence. No. Soda Springs St. (If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob Newman

6. DATE OF BIRTH (month, day and year) Nov-6-1855

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	1	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10. NAME OF FATHER David Taylor

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Everett Newman

(Address) Soda Springs Ida

15. Filed 12-15, 1930 Dr Russell Tigert
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928, to Sept, 1929

that I last saw her alive on Sept. 28, 1929

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(apoplexy)

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen. Debility

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Soda Springs Ida

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Russell Tigert M. D.

12-15, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Soda Springs Ida — Date of Burial: 12-15 1930

20. Undertaker: L D Whiteman — Address: Soda Springs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73189

PLACE OF DEATH

County of Caribou
City of (Meadowville) Ida
soda springs, Ida

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

2. FULL NAME David Cummings

(a) Residence. No. Soda Springs Ida St. 8/
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 20 - 1927

7. AGE Years 3 Months 6 Days 20 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Meadowville Idaho

PARENTS

10. NAME OF FATHER W. G. Cummings

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Jennie Bell.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Natasha H. Alleson
(Address) Soda Springs Ida

15. Filed 12-12, 1930 Dr Russell Sigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 11, 1930, to Dec. 12, 1930
that I last saw him alive on Dec. 11, 1930
and that death occurred, on the date stated above, at 8.30 P m.
The CAUSE OF DEATH* was as follows:
scarlet fever

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) 0

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Phys. Ex.
(Signed) Russell Sigert, M. D.
Dec 12, 1930 (Address) Soda Spgs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial 12-12 1930

20. Undertaker E. L. Whiteman — Address Soda Springs

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73190

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 32

2. FULL NAME R. J. Bens
(a) Residence. No. Soda Springs Ida St. 24
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Aug-24-1916
7. AGE Years 14 Months 3 Days 4 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Hi school boy.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Soda Springs Ida

PARENTS
10. NAME OF FATHER Albert Bens.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Soda Springs Idaho
12. MAIDEN NAME OF MOTHER Dora Panting
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Soda Springs

14. Informant Albert Bens.
(Address) Soda Springs Ida
15. Filed 11-30, 1930 Dr Russell Tigert Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930, to Nov. 28, 1930
that I last saw him alive on Nov. 28, 1930
and that death occurred, on the date stated above, at 10:45 a. m.
The CAUSE OF DEATH* was as follows:
Cerebro-spinal meningitis
..... (duration) ..... yrs. ..... mos. 8 ds.
CONTRIBUTORY (Secondary) none
0 (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? same
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? micro. Ex Spinal Fluid
(Signed) Russell Tigert, M. D.
11/30, 1930 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida
Date of Burial 11-29 1930
20. Undertaker C. D. Whiteman
Address Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73193

PLACE OF DEATH
County of Caribou
City of Soda Springs

Registration District No. 82
Primary Registration District No. 2159
(No.)
Local Registrar's No. 30

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Brown
(a) Residence. No. Soda Springs St. Idaho. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year)
7. AGE Years 62 | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) Ohio (State or country)

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) Unknown (State or Country)
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country)

14. Informant J. H. Wallace
(Address) Soda Springs Idaho
15. Filed 11-5, 1930 D. Russell Tight Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 4 (Day) - 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930 to Oct 29, 1930
that I last saw him alive on Oct 29, 1930
and that death occurred, on the date stated above, at 4 P m.
The CAUSE OF DEATH* was as follows:
Organic Heart Disease
(duration) yrs. 1 mos. ds.
CONTRIBUTORY (Secondary) Diabetes Mellitus
(duration) 2 yrs. mos. ds.
18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) Ellis Kaufman, M. D.
Nov. 5, 1930 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Soda Springs Ida — Date of Burial Nov 5 - 1930
20. Undertaker G. D. Fitzmaurice — Address Soda Springs Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73193

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Virginia May Brower

(a) Residence. No. ..... St. 24
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug. 15 1930

7. AGE Years | Months 2 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Arthur C Brower

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Lydia Brantner

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) North Dakota

14. Informant (Address) A.C.Brower Burley Idaho.

15. Filed 12-18-1930 F H Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 3 1930. (Month) (Day) (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov 3, 1930
that I last saw her alive on Nov 3 1930
and that death occurred, on the date stated above, at 7.30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Epidemic Spinal Meningitis

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Hugh E. Dean, M. D.
....., 19.... (Address) Burley Id.

19. Place of Burial, Cremation, or Removal Burley Ida
Date of Burial Nov.4-30 19

20. Undertaker D.E.Johnson Burley Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73196

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

16

2. FULL NAME Juaneta Bennett#

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W	S

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 15 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
				15 hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho

PARENTS

10. NAME OF FATHER Gordon Baker Bennett

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Esmerilda Tippets

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Utah

14. Informant (Address) G.B.Bennett Burley Ida

15. Filed 12-10-, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 15 1930 (Month) (Day) 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930, to Nov 15, 1930
that I last saw her ~~alive~~ on Nov 15, 1930
and that death occurred, on the date stated above, at — m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intra Uterine Complication

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) [illegible], M. D.
Nov 15, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Burley Ida	Nov. 17- 1930

20. Undertaker	Address
D.E.Johnson	Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 2? 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13[illegible]

PLACE OF DEATH
County of Cassia
City of Declo
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Allen Monroe Smith

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Smith

6. DATE OF BIRTH (month, day and year) July 11 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	3	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New York

PARENTS

10. NAME OF FATHER Oliver Cornwall Smith

11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12. MAIDEN NAME OF MOTHER Marion Burgen

13. BIRTHPLACE OF MOTHER (city or town) (State or County) N. Y.

14. Informant Mrs. Mary Smith
(Address) Declo Idaho.

15. Filed 12-10-, 1930 J. H. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 8 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6, 1930, to Nov 8, 1930, that I last saw him alive on Nov 8, 1930, and that death occurred, on the date stated above, at 12.[illegible] m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma
(duration) 1 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cachexia
(duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Joseph E. Lucas, M. D.
Nov 13, 1930 (Address) Burley Ida.

19. Place of Burial, Cremation, or Removal Declo Idaho. Date of Burial Nov 14 1930

20. Undertaker D. E. Johnson Address Burley

RECEIVED DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73193

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. .....

(No. 100 a .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Blaine Haight

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Singlr

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 24 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Pocatello
(State or country) Ida

PARENTS

10. NAME OF FATHER Merrill H Haight

11. BIRTHPLACE OF FATHER (city or town) Parker
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Dorothy Chugg

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Idaho.

14. Informant M.H.Haight
(Address) Burley Ida

15. Filed 12-16-, 1930. F.N. Carter Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1930, to Nov 20, 1930
that I last saw him alive on Nov 20, 1930
and that death occurred, on the date stated above, at 8:20 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.
....., 19..... (Address) Burley Ida

19. Place of Burial, Cremation, or Removal: Parker Idaho. Date of Burial: Nov. 23 1930

20. Undertaker: D.E.Johnson Burley Address: Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73199

PLACE OF DEATH
County of Cassia
City of Burley
Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Jean Parker 24

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 7 1929

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Burley
(State or country) Idaho

PARENTS

10. NAME OF FATHER Elwood Logan Parker

11. BIRTHPLACE OF FATHER (city or town) Ogden
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Larene Baum

13. BIRTHPLACE OF MOTHER (city or town) Provo
(State or County) Utah.

14. Informant E.L. Parker
(Address) Burley Idaho.

15. Filed Nov 15 —, 1930 F. K. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 2 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 -, 1930, to Nov 2, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 6:3[illegible] m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Epidemic Cerebro. Spinal Meningitis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY .....
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Epidemic
(Signed) Lloyd E. Olsen, M. D.
Nov 2-, 1930 (Address) Burley Ida

19. Place of Burial, Cremation, or Removal: Burley Ida — Date of Burial: Nov. 2 1930

20. Undertaker: D.E.Johnson — Address: Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73200

PLACE OF DEATH
County of Cassia
City of Burley

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mary Jane Chesley

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 12 1930

7. AGE — Years | Months | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Burley Ida

PARENTS

10. NAME OF FATHER Albert M Chesley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) West Virginia
12. MAIDEN NAME OF MOTHER Clellie May Russell
13. BIRTHPLACE OF MOTHER (city or town) (State or County) West Virginia

14. Informant (Address) A.M.Chesley Burley Ida

15. Filed 12-15-, 1930 T H Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 6 1930 (Month) (Day) (Year), 19...

17. I HEREBY CERTIFY, That I attended deceased from Nov 2, 1930, to Nov 6, 1930
that I last saw her alive on Nov 6, 1930
and that death occurred, on the date stated above, at 12. P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Erysipilas

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Patent Foramen Ovale

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) T H Cutler, M. D.
Nov 6, 1930 (Address) Burley

19. Place of Burial, Cremation, or Removal: Burley Ida
Date of Burial: Nov. 7 1930

20. Undertaker: D.E.Johnson Burley Ida. Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7324

PLACE OF DEATH
County of Clark
City of Spencer

Registration District No. 125
Primary Registration District No. 2203

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Doe

8 8 13

(a) Residence. No. St. nonresident
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Unknown

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 60			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) data obtainable

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant
(Address)

15. Filed Dec 27, 1930 C E Jones M D
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at about 10 a m.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis
Found dead in camp wagon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) C E Jones, M. D.
12/27, 1930 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Dubois Idaho	Dec 28 1930

20. Undertaker	Address
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73203

PLACE OF DEATH
County of Gem
City of Emmett

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Infant Daughter Clemmie Allen 1000

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 11 - 1930

7. AGE Years — Months — Days 12 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Emmett Ida

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER Clemmie Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho Falls Idaho

14. Informant (Address) W. O. Shirt Emmett Ida

15. Filed 12/23, 1930 E. J. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-22, 1930, to ....., 19....
that I last saw her alive on 12-22, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchial pneumonia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Influenza
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) R. N. Cummings, M. D.
12/23, 1930 (Address) Emmett

19. Place of Burial, Cremation, or Removal Emmett Idaho — Date of Burial 12/24 1930

20. Undertaker C. D. Bricknum — Address Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 15 1930

PLACE OF DEATH

County of Clark

City of Small

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 125

Primary Registration District No. 2203

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 73204

Local Registrar's No. .....

88B

2. FULL NAME Samuel C Hardesty

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret Hardesty

6. DATE OF BIRTH (month, day and year) July 16. 1845

7. AGE 85 Years | Months 4 | Days 9 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER Charles Hardesty

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Margaret Hardesty
(Address) Small Idaho

15. Filed Nov 26, 1930 C E Jones M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General debility

..... (duration) several yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C E Jones, M. D.

Nov 27, 1930 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~ Dubois Idaho | Date of Burial Nov 26 1930

20. Undertaker None. | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73205

PLACE OF DEATH
County of Clearwater
City of Weippe

Registration District No. 90
Primary Registration District No. 2157

Local Registrar's No. 93

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

REC. JAN 13 1931

2. FULL NAME Adonija Jordan

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
About	84			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) West Virginia
(State or country)

PARENTS

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (city or town) ✓
(State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (city or town) ✓
(State or Country)

14. Informant Jan Jordan
(Address) Orofino

15. Filed 11/20, 19.... W. A. Shaw
Registrar

MEDICAL CERTIFICATE OF DEATH

1113

16. DATE OF DEATH
Nov (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
11-/17, 19...., to 11/1, 19....
that I last saw h.... alive on 11/1, 1930
and that death occurred, on the date stated above, at 9:00 m.
The CAUSE OF DEATH* was as follows:

Dropsy cadse Influenza

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) W. F. Robertson, M. D.
11/7, 19.... (Address) Orofino

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Weippe Ida	11/2 19
20. Undertaker	**Address**
W. D. Pinson	Orofino

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73266

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187 Local Registrar's No. 95
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wallace Milton Hunter 57
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Nov 17 - 1916
7. AGE Years 14 Months 1 Days 10 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Peck Ida

PARENTS
10. NAME OF FATHER Milton N. Hunter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Frances Albert
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ida. Teakeau

14. Informant (Address) Milton N. Hunter
15. Filed 12/29, 1936 W. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1930, to Dec 20 h, 1930
that I last saw him alive on 12 - 20, 1930
and that death occurred, on the date stated above, at ..... m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetes -
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Malnutrition
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis? Tests
(Signed) W. F. Robertson, M. D.
12/29, 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal Gilbert. Date of Burial Dec 29 1930
20. Undertaker W. D. Pinson Address Orofino

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Wallace Milton Hunter

now lying buried in Gilbert Cemetery, in the City or Town of near Nezperce & Orofino

County of Clearwater State of Idaho, who died on the 27 day of December, 1930, Aged ____ years ____ months

____ days, the cause of death being Diabetes and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. W. F. Robertson attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private private or railway conveyance

to Kamiah Cemetery in the City or Town of Kamiah County of Lewis

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Clearwater it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 30th day of April, A.D. 1975.

Permit issued to:
Robert R. Hansen
Hansen-Noland Funeral Home
305 North Mill
Grangeville, Idaho 83530

Janet M. Wick
by Joyce B. Foltz Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____, 19__.

_____
Health Officer

FORM BH 56-019

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7326

PLACE OF DEATH
County of Clearwater
City of Weippe

Registration District No. 90
Primary Registration District No. 2187 Local Registrar's No. 94
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lenneane Lenore Hendrickson 80

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 24, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orofino Ida

PARENTS

10. NAME OF FATHER Oscar E Hendrickson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Beatie Snyder
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Weippe Ida

14. Informant (Address) Oscar E Hendrickson

15. Filed 12/29, 1930 H. E. Edman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 26, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to 12-25, 1930
that I last saw h[illegible] alive on 12-25, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Convulsions = Do not know
Cause. Maybe some thing she
picked up and ate - or Central Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? Dr. Smith Hendrickson (negative) -
What test confirmed diagnosis?
(Signed) H H Robertson, M. D.
12/27, 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal: Weippe — Date of Burial: Dec 28 1930

20. Undertaker: W D Simon — Address: Orofino

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73208

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2197
(No. Northern Idaho Sanitarium)
Local Registrar's No. 93

(If death occurred in a hospital or Institution, give its name instead of street and number.)

2. FULL NAME George St. Germain - 90

(a) Residence. No. ..... St. Boise - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 0 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? 59 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of unascertained

6. DATE OF BIRTH (month, day and year) May 9, 1857

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Lumberjack
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10. NAME OF FATHER Louis St. Germain
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada
12. MAIDEN NAME OF MOTHER Kate Patrick
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 12/23, 19.... H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1930 to Dec. 23, 1930
that I last saw him alive on December 22, 1930
and that death occurred, on the date stated above, at 2.27 A. m.
The CAUSE OF DEATH* was as follows:
General arteriosclerosis

(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Chronic alcoholic Psy.
Chorea
(duration) ? yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey M. D.
December 23 1930 (Address) Orofino Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Hatch	19
20. Undertaker	Address
H. A. Shaw	Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73209

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 2107
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 92

2. FULL NAME Charles Wesley Wert

(a) Residence. No. 88 13 St. Rathdrum, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wood Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15. Filed 1/23, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926 to December 21, 1930
that I last saw h[illegible] alive on December 21, 1930
and that death occurred, on the date stated above, at 12, 40 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Paranoid Condition
(duration) 23 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Signs
(Signed) John Irvine McKelvey, M. D.
December 21, 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho Sav. Cemetery	Dec. 22 1930
20. Undertaker	Address
J. A. Bielberg, Lesp. Attst.	Orofino, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7321

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 91
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME George W. Byers

(a) Residence. No. ..... St. Moscow, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? X yrs. X mos. X ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of Unascertained
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) United States

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino, Idaho

15. Filed Dec 14, 1930. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to December 12, 1930
that I last saw him alive on December 12, 1930
and that death occurred, on the date stated above, at 11.30 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the stomach
..... (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Paranoid condition
..... (duration) 27 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? X
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Crowe McKelvey, M. D.
December 12, 1930 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
N. Idaho Sanitarium Cemetery	Dec. 16 1930
20. Undertaker	Address
F. A. Billberg, Hosp. Attat.	Orofino, Idaho.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7321

PLACE OF DEATH
County of Clearwater
City of Weippe

CERTIFICATE OF DEATH

Registration District No. 90
Primary Registration District No. 2187
Local Registrar's No. 20
(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry William Leonard

(a) Residence. No. St. 10/13
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 26 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Orofino Ida

PARENTS

10. NAME OF FATHER Fred M. Leonard

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Grangeville Ida

12. MAIDEN NAME OF MOTHER Cora Ines Center

13. BIRTHPLACE OF MOTHER (city or town) (State or County) MO

14. Informant (Address) Mrs Fred M. Leonard

15. Filed 12/16, 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1930 to Dec 13, 1930
that I last saw him alive on Dec 13, 1930
and that death occurred, on the date stated above, at 9 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Whooping Cough

Malnutrition (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) W. H. Robinson, M. D.

12/15, 1930 (Address) Orofino Idaho

19. Place of Burial, Cremation, or Removal: Weippe — Date of Burial: Dec 15 1930

20. Undertaker: W. D. Brinson — Address: Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73213

PLACE OF DEATH

County of Clearwater

City of Orofino

Registration District No. 90

Primary Registration District No. 2187

Local Registrar's No. 88

(No. Northern Idaho Sanitarium)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edwin N. Carrico

(a) Residence. No. ..... St. Moscow, Idaho.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 4 yrs. 8 mos. 1 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unascertained

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE Years 73 Months ? Days ? If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Mining Prospector

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri Illinois

PARENTS

10. NAME OF FATHER Dennis H. Carrico

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Helen Catharine Carrico

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino, Idaho.

15. Filed 12/11, 19.. H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH 43

16. DATE OF DEATH December 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to December 8, 1930

that I last saw him alive on December 7, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of lip, cheek and jaw.

..... (duration) 3 yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Senile psychosis

..... (duration) 5 yrs. + mos. + ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M. D.

December 9 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: No. Idaho Sanitarium Cemetery — Date of Burial: Dec. 10 1930

20. Undertaker: F. A. Billberg, Hosp. Attdt — Address: Orofino - Idaho

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73214

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 0218
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 87

2. FULL NAME Richard Milloy.

(a) Residence. No. 129 St. Orofino, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 3 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? 27 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of Unascertained
. (or) WIFE of .

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	66	?	?	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10. NAME OF FATHER Patrick Milloy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Blanche Milloy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland.

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 12/11, 19__ H. A. Shaw Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15, 1927, to December 8, 1930
that I last saw him alive on December 7, 1930
and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis.
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Psychosis mid cerebral arterio-sclerosis (duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? Prior to admission
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McElwee, M. D.
December 9, 1930 (Address) Orofino, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
No. Idaho Sanitarium Cemetery	Dec. 9 1930
20. Undertaker	Address
F. A. Billberg, Hosp. Attdt	Orofino - Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73215

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 96
Primary Registration District No. 2187
Local Registrar's No. 96
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joe Fibis

(a) Residence. No. 44 St. Sand Point, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 17 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Unascertained

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Unascertained			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10. NAME OF FATHER Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unascertained
12. MAIDEN NAME OF MOTHER Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unascertained

14. Informant Records: Northern Idaho Sanitarium
(Address) Orofino - Idaho.

15. Filed 12/11, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 7 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to December 7, 1930
that I last saw him alive on December 7, 1930
and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of pylorus.
(duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Dementia praecox, paranoid type (duration) 17 yrs. + mos. + ds.

18. Where was disease contracted ? if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) John Irvine McKelvey, M. D.
December 7 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Northern Idaho San. Cemetery	Dec. 8 1930
20. Undertaker	Address
F. A. Billberg, Hosp. Attdt.	Orofino - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73216

PLACE OF DEATH
County of Clearwater
City of Orofino

Registration District No. 90
Primary Registration District No. 2187
(No. Northern Idaho Sanitarium)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 85

90

2. FULL NAME William Kennison -

(a) Residence. No. ..... St. Moravia - Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Unascertained

6. DATE OF BIRTH (month, day and year): Unascertained

7. AGE: Years 81 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Railroad laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Vermont

PARENTS

10. NAME OF FATHER: Unascertained
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unascertained
12. MAIDEN NAME OF MOTHER: Unascertained
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unascertained

14. Informant: Northern Idaho Sanitarium
(Address) Orofino - Idaho -

15. Filed Dec 2, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1926, to December 2, 1930
that I last saw him alive on December 1, 1930
and that death occurred, on the date stated above, at 4.30 A.m.
The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(Mitral regurgitation)
..... (duration) ? yrs. ? mos. ? ds.
CONTRIBUTORY (Secondary) Paranoid Condition
..... (duration) 26 yrs. ? mos. ? ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) John Irvine McKelway, M. D.
December 2 1930 (Address) Orofino - Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cemetery, No. Idaho Sanitarium
Date of Burial: Dec. 2 1930

20. Undertaker: F. A. Billberg - Hosp. Attdt.
Address: Orofino - Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73217

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Custer
City of Mackay
Registration District No. 76
Primary Registration District No. 2153
Local Registrar's No. 138
(No. 179)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Brown Ewing

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 6 - 1873

7. AGE: Years 57 | Months 11 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer on ranch
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Lincoln, Ill.

PARENTS

10. NAME OF FATHER John Levi Ewing
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lincoln, Ill.
12. MAIDEN NAME OF MOTHER Ruth Nicholson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) [illegible]

14. Informant Harvey Ewing
(Address) Mackay, Ida.

15. Filed Jan. 2, 1931 Rose Newcomb Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 15 (Day) 30, 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/9/30, 19..., to 12/15/30, 19...
that I last saw him alive on 12/11/30, 19...
and that death occurred, on the date stated above, at 4 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Nephritis, Chronic.
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) MYOCARDITIS.
(duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical signs.
(Signed) [illegible], M. D.
12/16/30, 19... (Address) Mackay, Idaho

19. Place of Burial, Cremation, or Removal: M. M. Caleb - Mackay, Ida. Date of Burial: Dec 17 1930

20. Undertaker: Gladys Garner Address: Arco Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73216

PLACE OF DEATH
County of Buster
City of Mackay

Registration District No. 76
Primary Registration District No. 2153 Local Registrar's No. 137
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth Nicholson Ewing 68B

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 44 yrs. mos 3 ds. 1 How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruben Henry Ewing

6. DATE OF BIRTH (month, day and year) Feb. 26 - 1856

7. AGE Years 74 Months 9 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lake Ohio Mich

PARENTS
10. NAME OF FATHER Aaron Brown Nicholson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Ann Eastman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Vermont

14. Informant (Address) Mrs. Florence Longson, Mackay Ida

15. Filed Jan 2, 1931. Rose Nowack Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-26-30, 19....., to 12-1-30, 19.....
that I last saw her alive on 12/1/30, 19.....
and that death occurred, on the date stated above, at 10:15 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Carroll A B Jensen M. D.
....., 19..... (Address) Mackay Ida

19. Place of Burial, Cremation, or Removal Mt. McCaleb Cemetary
Date of Burial 12/4 1930

20. Undertaker Gladys Farmer
Address Arco Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13219

PLACE OF DEATH
County of Custer
City of Challis
Registration District No. 108
Primary Registration District No. 2186
Local Registrar's No. 113
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Clarence C. Burstedt
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Beith Burstedt

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30	10	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Abstractor
(b) General nature of industry, business, or establishment in which employed (or employer) Court House
(c) Name of employer County

9. BIRTHPLACE (city or town) (State or country) Moore Butte Co. Idaho

PARENTS

10. NAME OF FATHER Peter Burstedt
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Matilda Soderwark
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Sweden

14. Informant Mrs. Beith Burstedt
(Address) Challis, Idaho

15. Filed Jan 3 1931 Elma McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 30th
12 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12/25 1930, to 12/30 1930,
that I last saw him alive on 12/30 1930,
and that death occurred, on the date stated above, at 2:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. B. McKinley, M. D.
1930 (Address) Challis, Ida.

19. Place of Burial, Cremation, or Removal Challis, Idaho. Date of Burial Jan. 1 1931
20. Undertaker Wm C. Doble Address Salmon, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7322

PLACE OF DEATH
County of Custer
City of Challis
Registration District No. 18
Primary Registration District No. 2186 Local Registrar's No. 111
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

740

2. FULL NAME Willis Bonner Brownlee

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 17 - 1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	8	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Little York
(State or country) Warren County Ill.

PARENTS

10. NAME OF FATHER John Brownlee
11. BIRTHPLACE OF FATHER (city or town) Claysville
(State or Country) Washington Co Penn
12. MAIDEN NAME OF MOTHER Nancy Ann Ross
13. BIRTHPLACE OF MOTHER (city or town) Canby
(State or County) Hancock Co Ohio

14. Informant R L Brownlee
(Address) Little York Ill

15. Filed Dec 8, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 6th. 1930
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 2d. 1930, to Dec. 6th 1930
that I last saw him alive on Dec. 6th. 19
and that death occurred, on the date stated above, at 1:45 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 30 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. L. Hurley M. D.
12/8 1930 (Address) Challis, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Little York, Ill.	Dec 17 1930
20. Undertaker V. F. McHan	Address Idaho Falls Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73221

PLACE OF DEATH
County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 110
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Henry Smith 101a
(a) Residence. No. Challis Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Agnes Ida Smith

6. DATE OF BIRTH (month, day and year) March 24 1865

7. AGE Years 65 Months 7 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Challis High School

9. BIRTHPLACE (city or town) Cincinnati Ohio
(State or country)

PARENTS
10. NAME OF FATHER Louis Smith
11. BIRTHPLACE OF FATHER (city or town) Germany
(State or Country)
12. MAIDEN NAME OF MOTHER Mary E Forty
13. BIRTHPLACE OF MOTHER (city or town) Cincinnati Ohio
(State or County)

14. Informant (Address) Mrs Henry Smith

15. Filed Nov. 7, 1930 Edna McKinney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 4th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from for several years, 19
that I last saw him alive on Nov. 4, 1930
and that death occurred, on the date stated above, at 11 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Arterio Sclerosis
10 (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. S. Kirtley, M. D.
4/6, 1930 (Address) Challis Ida

19. Place of Burial, Cremation, or Removal Challis, Idaho
Date of Burial Nov. 7, 1930

20. Undertaker Mrs Thos Garnier
Address Ares, Idaho

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73222

PLACE OF DEATH
County of Franklin
City of Preston
Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 88
(No.) 74 W
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Della Eline

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 28 1868

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	10	24	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work NONE
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hanover PeNnn

PARENTS

10. NAME OF FATHER Amos Leschey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Emma Hart
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Charles Eline
(Address) Preston

15. Filed 12/10/ 1930 T. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1930, to Nov 22, 1930
that I last saw her alive on Nov. 21, 1930
and that death occurred, on the date stated above, at 3 a m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Cirrhis Selerosis
(duration) 6 yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) G. W. Stokes, M. D.
Nov. 23 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Nov 25 30 19
20. Undertaker M. W. Hendricks	Address Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73223

Local Registrar's No. 89

1013

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rosa Lions

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	Mexican	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 9 30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	II	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Los Angeles

PARENTS

10. NAME OF FATHER Joe Lions

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Carmel Ramises

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mexico

14. Informant Joe Lions
(Address) New Mexico

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 20 (Day) 1930 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 3 days mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) M Hancey Coroner M. D.
Dec 20, 1930 (Address) Preston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho	Nov 22 30 19

20. Undertaker M. W. Hendricks Address Preston

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73224

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No.
Primary Registration District No.
Local Registrar's No. 90

(No. 740)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Gill

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 9 1864

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	II	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Work in store
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER Robert Gill
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Sarah Millington
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Mrs Robert Gill
(Address) Preston Idaho

15. Filed 1-7-31, 19.. C. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec 7, 1930
that I last saw him alive on Dec 6, 1930
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:
Cerebral apoplexy
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Arterio sclerosis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) David R. Cutler, M. D.
Dec 7, 1930 (Address) Preston, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Preston Idaho Dec	II 30 19
20. Undertaker M. W. Hendrick s	Address Pre ston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73225

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119 Local Registrar's No. 93
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada Dahle Sparrow

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	white	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 19 1916

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	14	6	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Logan Utah

PARENTS

10. NAME OF FATHER Chs. Sparrow
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Newton Utah
12. MAIDEN NAME OF MOTHER Athel May Dahle
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Logan

14. Informant (Address) Chs. Sparrow Preston Idaho

15. Filed 12/18/30 19.... A. R. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1930 to Dec 15 1930
that I last saw h.. alive on Dec 15 1930
and that death occurred, on the date stated above, at 1:05 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rheumatic Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Residence
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Orval R. Cutler M. D.
Dec 18 1930 (Address) Preston, Idaho

19. Place of Burial, Cremation, or Removal: Logan Utah — Date of Burial: Dec. 20 1930

20. Undertaker: M. W. Hendricks — Address: Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73226

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2119 Local Registrar's No. 94
(No. Gen. Mem. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Hodges. 206

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 12/26/30.

7. AGE Years | Months | Days ✓ | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston Ida.

PARENTS
10. NAME OF FATHER George Edwin Hodges
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewiston Ut.
12. MAIDEN NAME OF MOTHER Verda Larson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Clifton

14. Informant (Address) George Edwin Hodges Preston

15. Filed 12/26/ 1930. J. R. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12/ 26/ 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/26/30, 19..., to 12/26/30, 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Placenta Previa
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Eugene Farley, M. D.
12/26/30, 19... (Address) Preston

19. Place of Burial, Cremation, or Removal Preston | Date of Burial 12/26/30.

20. Undertaker none | Address —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 13267

PLACE OF DEATH

County of Franklin
City of Preston

CERTIFICATE OF DEATH

Registration District No. 27
Primary Registration District No. 2119 Local Registrar's No. 95
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wm. Ova Anderson 45

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
male	white	marreid

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Millie G. Anderson

6. DATE OF BIRTH (month, day and year) Mar 5 1873

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	9	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Park City Utah

PARENTS

10. NAME OF FATHER Wm. Ova Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Elsie Erickson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Mrs Millie G. Anderson Preston Idaho

15. Filed 12/31/30 19..... A. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1930, to Dec 31, 1930
that I last saw him alive on Dec 30, 1930
and that death occurred, on the date stated above, at 7:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Rectum

..... (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ✓
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓ By Dr E. Radley
Did an operation precede death? Yes Date of soda Spr Ida
Was there an autopsy? No Clinical
What test confirmed diagnosis?
(Signed) G. W. Stokes, M. D.
Dec 31, 1930 (Address) Preston Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Salt Lake City Utah	Jan 4 30

20. Undertaker	Address
M. W. Hendricks	Preston Idaho

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13226

PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

1a

2. **FULL NAME** Dean Allen Gamble

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hazel McClurg Gamble

6. DATE OF BIRTH (month, day and year) Jan 2I I902

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	II	IO	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Franklin

PARENTS

10. NAME OF FATHER Geo Gamble

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Alice Sidaway

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Salt Lake Utah

14. Informant Geo Gamble
(Address) Franklin

15. Filed 12/31, 1930. J. R. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec - 31 - , 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 - , 1930, to Dec 31 , 1930
that I last saw h[illegible] alive on Dec 30 , 1930
and that death occurred, on the date stated above, at 5 30 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Typhoid fever -

.....(duration) - yrs. - mos. 28 ds.

CONTRIBUTORY (Secondary) -

.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Preston Idaho
Did an operation precede death? no Date of -
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) G. W. Slater, M. D.
Dec 31, 1930 (Address) G. W. Slater

19. Place of Burial, Cremation, or Removal	Date of Burial
Presto Idaho	Jan 3 3I 19

20. Undertaker M. W. Hendricks Address Preston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73229

Registration District No. 27
Primary Registration District No. 2119
Local Registrar's No. 87

PLACE OF DEATH
County of Franklin
City of Clifton
(No.) 205-b
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dan Owen Viehweg

(a) Residence. No. Clifton St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or ~~Divorced~~ (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 3, 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clifton

PARENTS
10. NAME OF FATHER Carl D. Viehweg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Clifton
12. MAIDEN NAME OF MOTHER Velma Vennerdahl
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Quincy Ill.

14. Informant Carl D. Viehweg
(Address) Clifton

15. Filed 12/3/, 1930 C. R. Cutler Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Natural Death
Cause unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. R. Cutler M. D.
, 19 (Address) Preston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clifton Ida.	12/4/30 19
20. Undertaker	Address
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73230

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Frnaklin

City of Minkcreek

Registration District No. 27

Primary Registration District No. 2119 Local Registrar's No. 92

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

94a

2. **FULL NAME** Louis O. Keller

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alberthana Keller

6. DATE OF BIRTH (month, day and year) April 27 1875

7. AGE Years 55 Months 7 Days 16 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minkcreek Idaho

PARENTS

10. NAME OF FATHER Theadore Keller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Christena Larsen

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) Mrs Louis Keller Minkcreek Idaho

15. Filed 12/14/30 19.... [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

[signature]

[signature]

..... (duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) 20 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) M. Hancey Coroner, ~~M.D.~~

....., 19..... (Address) Preston Ida

19. Place of Burial, Cremation, or Removal Minkcreek Idaho — Date of Burial Dec. 15 1930

20. Undertaker M. W. Hendricks — Address Preston Idaho

RECEIVED JAN 5 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7323

PLACE OF DEATH
County of Franklin
City of Weston
Registration District No. 27
Primary Registration District No. 2119 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Deane Baker

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	W.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 11/26/30.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Weston

PARENTS

10. NAME OF FATHER Harold E. Baker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Franklin Ida
12. MAIDEN NAME OF MOTHER Alice Gilbert
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Fairview

14. Informant Harold Baker
(Address)

15. Filed 12/12/, 1930 J. B. Cutler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 12, 1930, that I last saw him alive on Dec 12, 1930, and that death occurred, on the date stated above, at 7 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Age.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Edgar Hosley M. D.
Dec 12, 1930 (Address) Preston Ida

19. Place of Burial, Cremation, or Removal: Weston — Date of Burial: 12/15/1930
20. Undertaker: None — Address:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

PLACE OF DEATH

County of Fremont

City of St. Anthony, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 99

Primary Registration District No. 2177

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE
State File No. 73232

Local Registrar's No. 365

2. FULL NAME Doris Jean Hobbs

(a) Residence. No. St. Anthony, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1000

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) September 9th, 1930

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
XXXX	3	17	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Twin Groves Idaho.

PARENTS

10. NAME OF FATHER: Ernest Hobbs

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Twin Groves Idaho.

12. MAIDEN NAME OF MOTHER: Mabel Abbeglen

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Wilford Idaho.

14. Informant: Ernest Hobbs

(Address) St. Anthony, Ida Route 2

15. Filed Dec. 26th, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 26th, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1930, to Dec. 26, 1930

that I last saw her alive on Dec. 26, 1930

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Broncho-Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Accidental burn on Butt

(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Lungs & sore

(Signed) P. M. Kelly, M. D.

, 19 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford

Date of Burial: Dec. 27th, 1930

20. Undertaker: W. M. Hansen

Address: St. Anthony, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73233

PLACE OF DEATH
County of Fremont
City of Parker

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 364

2. FULL NAME Rose Barton

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

1000

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 14-1930.

7. AGE Years | Months 2 | Days 27 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) P. Elk. Wyoming

PARENTS

10. NAME OF FATHER Jack. Barton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Katherine Taylor
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Victor Idaho.

14. Informant (Address) Jack. Barton Parker Ida.

15. Filed Dec 11th, 1930 W. M. Hansen Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 11th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6, 1930, to Dec 11, 1930
that I last saw her alive on Dec 10, 1930
and that death occurred, on the date stated above, at 8 30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastro enteritis.
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) T. A. Ellison, M. D.
Dec 11, 1930 (Address) St. Anthony Ida

19. Place of Burial, Cremation, or Removal Parker Ida. | Date of Burial Dec. 12 1930

20. Undertaker Vern J. Keller | Address Rexburg Ida.

RECEIVED JAN 2 1931

PLACE OF DEATH

County of Fremont

City of St Anthony

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73234

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 363

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Rowena Winters

(a) Residence. No. ..... St. Chester 9 Ida

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6. DATE OF BIRTH (month, day and year): June 5 1930

7. AGE Years: Months 6 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country): Chester

PARENTS

10. NAME OF FATHER: Allen Winters

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Chester

12. MAIDEN NAME OF MOTHER: Mary Beck

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Springfield Ill

14. Informant: Allen Winters

(Address)

15. Filed Dec 9, 1930 W M Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1930, to Dec 8, 1930

that I last saw her alive on Dec 8 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis Complicated with Meningitis Eff Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) W Bell est, M. D.

....., 19.... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wilford

Date of Burial: Dec 10 1930

20. Undertaker: W M Hansen

Address: St. Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73235

PLACE OF DEATH

County of Fremont

City of St. Anthony, Ida

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 362

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

129

2. FULL NAME Alex C. Wallace

(a) Residence. No. St. Anthony, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Devorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 25th, 1860

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	10	23	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Rug Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Not Known

PARENTS

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known

14. Informant: Small book found in room
(Address)

15. Filed Nov. 19th, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 17th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17th, 1930, to Nov. 17, 1930
that I last saw him alive on Nov. 17, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis (Chronic)

(duration) 1 yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine & Heart.

(Signed) J. M. Kelly, M. D.

, 19 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview St. Anthony, Ida

Date of Burial: Nov. 19-1930

20. Undertaker: W. M. Hansen St. Anthony, Ida
Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73236

PLACE OF DEATH

County of Fremont

City of Island Park

Registration District No. 99

Primary Registration District No. 2177

Local Registrar's No. 361

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Andrew Nelsen

(a) Residence. No. Ashton, Idaho. St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

74a

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Not Known

7. AGE: About Years 65 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tie Hacker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Smead

9. BIRTHPLACE (city or town) (State or country) Sweden or Danmark

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Mr Smead and others
(Address) Ashton, Idaho.

15. Filed Nov. 13th, 1930 W. M. Hansen Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 12th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw him ~~xxxx~~ Dead Nov. 12th, 1930

and that death occurred, on the date stated above, at 6 P. M. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. M. Hansen Co. Conorer, M. D.

Nov. 13th, 1930 (Address) St. Anthony, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverview St. Anthony, Ida | Date of Burial: Nov. 15 1930

20. Undertaker: W. M. Hansen St. Anthony, Idaho. | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

County of .....

City of Pelow

Registration District No. 14

Primary Registration District No. 2177

Local Registrar's No. 360

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Donaldson

(a) Residence. No. ..... St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

45

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 30-1842

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) London England

PARENTS

10. NAME OF FATHER Wm Donaldson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Rachel Holman

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Elma Donaldson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 10, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1930, to Feb. 10, 1930
that I last saw him alive on Feb. 8th, 1930
and that death occurred, on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of Bowel

(duration) 3 yrs. mos. ds.

CONTRIBUTORY .....
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Tumor mass

(Signed) P. M. Kelly, M. D.

Feb. 10, 1930 (Address) St. Anthony, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal | Date of Burial

ry important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No.

(No. , St.)

File No. 73238

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas J Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1847 (Year)

7. AGE: 82 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John A Williams

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Paulina Sublett

13. BIRTHPLACE OF MOTHER (State or Country): Ken.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Warren Williams

(Address) Hagerman

15. Filed Aug 19 1930 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

164

16. DATE OF DEATH: Aug (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1930, to Aug 16 1930, that I last saw him alive on Aug 16 1930, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows: Aug 18 - 1930

General Decline

(Duration) 9 Yrs. mos. ds.

Contributory (Secondary) Pleurisy

(Duration) From Aug 14 - 18 - 30 yrs. mos. ds.

(Signed) R H Greene M. D.

Aug 19 1930 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman

DATE OF BURIAL: Aug 20 1930

20. UNDERTAKER: L J Johnson

ADDRESS: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence give facts called for under special information.

Registration District No. 71

Primary Registration District No.

(No. ..... St.)

File No. 73229

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Richard Rawlings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1893 (Year)

7. AGE: 36 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Rawlings

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lottie Inglet

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emerson Chapman

(Address) Hagerman

15. Filed Oct 6 1930 R. H. Green M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1930 to ..... 19..... that I last saw him alive on Oct 5 1930, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows: Heart trouble with Asites

(Duration) 9 Mos. mos. ds.

Contributory (Secondary) Kidney affection

(Duration) 5 yrs. mos. ds.

(Signed) R. H. Green M. D.

Oct 1930 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Tetonia Ida

DATE OF BURIAL: Oct 8 1930

20. UNDERTAKER: Evans & Johnson

ADDRESS: Hagerman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21

Primary Registration District No.

File No. 1324

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mariah Louise Stanwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March 24 (Month) (Day) 1853 (Year)

7. AGE: 77 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Charles Heber

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Adams

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O L Mills

(Address) Hagerman Ida

15. Filed Oct 7 1930 R H Greene M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH 11b

16. DATE OF DEATH: Oct (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1930 to Oct 6 1930 that I last saw her alive on Oct 6 1930, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Influenza

10 days (Duration) Yrs. mos. ds.

Contributory (Secondary) Aged

(Duration) yrs. mos. ds.

(Signed) R. H Greene M. D.

Oct 7 1930 (Address) Hagerman Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL: Oct 12 1930

20. UNDERTAKER: A. E. Thompson ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. [illegible] RECEIVED JAN 7 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 1324
Registered No. 143

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orsen P. Pratt.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 8th 1902 (Month) (Day) (Year)

7. AGE: 28 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Parley P. Pratt.

11. BIRTHPLACE OF FATHER: X (State or Country)

12. MAIDEN NAME OF MOTHER: Nellie N Tate

13. BIRTHPLACE OF MOTHER: X (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ultra Pratt
(Address) Gooding Ida.

15.
Filed 19 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1930, to Dec 22 1930, that I last saw h[illegible] alive on Dec 22 1930, and that death occurred on the date stated above, at 12:15 M.

The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Rheumatic Fever
(Duration) yrs. mos. 20 ds.

(Signed) Houston E Snyder M. D.
12-22 1930 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 13242
Local Registrar's No. 14-2

1. PLACE OF DEATH JAN 7 1931
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene Adelbert Borthwick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	widower

6. DATE OF BIRTH: June (Month) 22 (Day) 1845 (Year)

7. AGE: 85 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farming
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): New York State

10. NAME OF Father: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. L. Randolph
(Address) Gooding Ida.

15. Filed 12-31- 1930 J N Cromwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH 13

16. DATE OF DEATH: Dec. (Month) 29- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-1- 1930, to 12-29- 1930
that I last saw h alive on 12-14- 1930,
and that death occurred on the date stated above, at 3:45 P.M.
The CAUSE OF DEATH* was as follows:
Cardio-vascular-renal disease
Chronic Brights disease
(Duration) 3 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J N Cromwell M. D.
12/30 1930 (Address) Gooding, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elmwood Cemetery — DATE OF BURIAL: 12-30- 1930

20. UNDERTAKER: A. E. Thompson — ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73243

PLACE OF DEATH
County of Idaho
City of Harpster
Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 42
(No.) 90
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Phillip Sheridan Grinwr

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ara Griner

6. DATE OF BIRTH (month, day and year) Aug 28, 1869

7. AGE	Years	Months	Days	If LESS than 1 day,
	61	4	1	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wheat farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l farming
(c) Name of employer none

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER John Griner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Don't know
12. MAIDEN NAME OF MOTHER Elizabeth Canrahan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Pennsylvania

14. Informant Ara Griner
(Address) Harpster, Idaho

15. Filed 12-31-, 1930 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 29th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22, 1930 to Dec 29, 1930
that I last saw him alive on Nov. 20, 1930
and that death occurred, on the date stated above, at 1:00 P M.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. A. Shemick, M. D.
12-29- 1930 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Harpster Ida.	12-31- 1930
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73241

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Idaho
City of Cottonwood

Registration District No. 163
Primary Registration District No. 2181
Local Registrar's No. 41
(No. 117)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Verla Eustana Fuller

(a) Residence. No. (Usual place of abode.) St. (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
17	1	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Single
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pomeroy Washington.

PARENTS

10. NAME OF FATHER Frank Fuller

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Washington

12. MAIDEN NAME OF MOTHER Lucy Mable Dove

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant Frank Fuller
(Address) Lucile, Idaho

15. Filed 12-31-, 1930. B. Chapman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 24 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1930, to Dec. 24, 1930, that I last saw her alive on Dec. 24-, 1930, and that death occurred, on the date stated above, at 5. P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 12-20-30
Was there an autopsy? No
What test confirmed diagnosis? Surgical Appendix
(Signed) B. Chapman, M. D.
12-26-, 1930 (Address) Grangeville Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville	12/27 1930

20. Undertaker Vassari Address Grangeville Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73245

PLACE OF DEATH

County of Idaho
City of Grangeville

CERTIFICATE OF DEATH

Registration District No. 103
Primary Registration District No. 1001 Local Registrar's No. 40
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Prudence Call
(a) Residence. No. ..... St. 129
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles C Call

6. DATE OF BIRTH (month, day and year) 1837 Ap 4

7. AGE Years 93 Months 8 Days 9 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House W
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) State of Maine

PARENTS

10. NAME OF FATHER Jeptha Fawster
11. BIRTHPLACE OF FATHER (city or town) (State or Country) .....
12. MAIDEN NAME OF MOTHER Ann Hobey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) .....

14. Informant (Address) Carlos Chambers Call

15. Filed 12-31- 1930 Grangeville Idaho B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 13 (Month) (Day) 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1929, to Dec. 12, 1930
that I last saw her alive on Dec 12, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Primary findings
(Signed) B. Chipman M. D.
12-27- 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial 12-15 1930

20. Undertaker Hancock Mnd Co. Address Grangeville

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 1[illegible]

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 1001
Local Registrar's No. 39
(No. 740)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Isac Zehner

(a) Residence. No. [illegible] St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Carla J Zehner

6. DATE OF BIRTH (month, day and year) 1853

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	Feb	19	40 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill

PARENTS

10. NAME OF FATHER Joseph Zehner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER McClure
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill

14. Informant (Address) Mrs Ida Zehner

15. Filed 12-31-30 California Co Angeles
[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 10, 1930, to Dec 3, 1930,
that I last saw him alive on Dec 3, 1930,
and that death occurred, on the date stated above, at 7 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
H. B. P.
Cerebral Hemorrhage
(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Symptoms

(Signed) J S Fisher, M. D.
Dec 17, 1930 (Address) Grangeville

19. Place of Burial, Cremation, or Removal: Grangeville Ida. — Date of Burial: 12-5 1930

20. Undertaker: Hancock Mtg Co — Address: Grangeville Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73247

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Idaho
City of Lapwai

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 38
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Milam R Leonard

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florinda Leonard

6. DATE OF BIRTH (month, day and year) 1858

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10. NAME OF FATHER James Leonard
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N. Y
12. MAIDEN NAME OF MOTHER ~~Brown~~
13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant (Address) R. L. D. Leonard Lenore Ida

15. Filed 12-31-, 1930 B. Chipman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 -, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13, 1930, to Nov. 22, 1930, that I last saw him alive on Nov. 22-, 1930 and that death occurred, on the date stated above, at 10 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of the Prostate

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Enlarged Prostate

(Signed) B. Chipman, M. D.
12-10-, 1930 (Address) Grangeville Ida.

19. Place of Burial, Cremation, or Removal: Denver Idaho — Date of Burial 12-11-1930

20. Undertaker: Hancock Mtd. Co. — Address: Grangeville Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED DEC 15 1930

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Cottonwood

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

File No. 73248

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kathleen Doris Scherer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 12 (Day) 1930 (Year)

7. AGE ✓ Yrs. ✓ Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Cottonwood, Ida.

10. NAME OF FATHER Geo. Scherer

11. BIRTHPLACE OF FATHER (State or Country) Uniontown, Wash.

12. MAIDEN NAME OF MOTHER Mary Moriarity

13. BIRTHPLACE OF MOTHER (State or Country) Westlake, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Scherer

(Address) West Lake Idaho

15.

Filed 11-15 1930 W. F. Orr per J. B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

206

16. DATE OF DEATH Nov (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-12 1930, to Nov. 14 1930, that I last saw her alive on Nov-14 1930, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Compression due to difficult Labor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley Orr M. D.

11/14 1930 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho

DATE OF BURIAL: 11/15 1930

20. [redacted] Father Willebrand Cottonwood Ida.

ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

RECEIVED JAN 12 1931

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 73249

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Cottonwood

Registration District No. 105

Primary Registration District No. 2183

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Keene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar. 12 (Month) (Day) 1877 (Year)

7. AGE: 53 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Small Sawmill & Farm.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Francis Keene

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER E. Cuman

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Keene

(Address) Cottonwood Ida.

15.

Filed 12-10 1930

W. F. Orr M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1930, to Dec 8 1930, that I last saw him alive on Dec 8 1930, and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Ruptured appendix.

Abdomen drained on Dec 6th 1930

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wesley Orr M. D.

12/8 1930 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick Ida — DATE OF BURIAL: 12-10 1930

20. UNDERTAKER: A A Nau — ADDRESS: Cottonwood

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 19 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 1320
Registered No. 22

1. PLACE OF DEATH
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sidney P. Triplett

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: February (Month) 22 (Day) 1841 (Year)

7. AGE: 89 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James P. Triplett
(Address) Cottonwood, Ida.

15. Filed Dec. 29 1930 N. F. Orr Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 90
7 (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24- 1927, to 7-15 1930, that I last saw h. alive on 7-15- 1930, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) Three yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. A. Woodcock M. D.

9-16 1930 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cottonwood, Ida. DATE OF BURIAL: 7-19 1930

20. UNDERTAKER: Vassars ADDRESS: Lewiston, Idaho

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 19 1931

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105

Primary Registration District No. 2183

File No. 7325

Registered No. 23

1. PLACE OF DEATH.

County of Idaho

City of Lamont

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katherine Arnzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. June (Month) 27 (Day) 1851 (Year)

7. AGE: 79 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lamont Ida

10. NAME OF FATHER: John Deckmann

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Born Lost

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank H Arnzen

(Address) Lamont Idaho

15.

Filed Dec. 22 1930

H. F. Orr M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1930 (Year) 8813

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1930, to Dec. 21 1930, that I last saw her alive on Dec. 20 1930, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) Wesley Orr M. D.

12/21 1930 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: 12-23 1930

20. UNDERTAKER: A H Nau — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 12 1931

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Cottonwood

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

File No. 73252

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Joseph Riener

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 15 (Day) 1930 (Year)

7. AGE ✓ Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... ✓

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clem Riener

11. BIRTHPLACE OF FATHER (State or Country) Herndon, Kansas

12. MAIDEN NAME OF MOTHER Margaret Schmidt

13. BIRTHPLACE OF MOTHER (State or Country) Green Creek, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clem Riener

(Address) Cottonwood, Ida.

15. Filed Dec. 28 1930 W. F. Orr per J.B. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 80

Dec. (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/27-8 AM 1930, to 12/27-5 PM 1930, that I last saw him alive on 12/27 1930, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions!

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wesley Orr M. D.

12/27 1930 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood, Ida. DATE OF BURIAL: Dec. 28 1930

20. UNDERTAKER: Fr. Willibrord, Cottonwood ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, with unfading ink—this is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 66

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registered No. 73253

1 PLACE OF DEATH
County Idaho State Idaho
Township ____ or Village Lamiah Vicinity or
City ____ No. ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna May Dickson

114

(a) Residence. No. Lamiah, Ida. St., ____ Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	W/8 Nez Perce Indian	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	3			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lamiah
(State or country) Idaho

PARENTS

10 NAME OF FATHER James L. Dickson
11 BIRTHPLACE OF FATHER (city or town) Lapwai
(State or country) Ida.
12 MAIDEN NAME OF MOTHER Josephine Corbett
13 BIRTHPLACE OF MOTHER (city or town) Lamiah
(State or country) Ida.

14 Informant Ruth C. Jackson
(Address) Lamiah Ida.

15 Filed Sept 6, 1930 A. M. Maxwell REGISTRAR

13—6194 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1930

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

Gastro - Enteritis
No physician in attendance reported
____ (duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY ____
(SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
If not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) ____, M. D.
____, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lamiah Cemetery	Sept 9 1930
20 UNDERTAKER	ADDRESS
Geo W. Tenary	Kooskia

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73254

PLACE OF DEATH
County of Jerome
City of Hazelton

Registration District No. 23
Primary Registration District No. 2017
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 9 1931

1-8-31

2. FULL NAME Emma J. Short
(a) Residence. No. Hazelton Ida Route #1 St. 107
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of R. O. Short
6. DATE OF BIRTH (month, day and year) June 15
7. AGE Years 57 Months Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Cole County, Mo.

PARENTS
10. NAME OF FATHER Redmond
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant R. O. Short
(Address) Hazelton Ida. Route #1
15. Filed 1-1, 1931 S Hopper Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 28 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from —, 19—, to —, 19—
that I last saw h— alive on —, 19—
and that death occurred, on the date stated above, at 11:45 P.m.
The CAUSE OF DEATH* was as follows:
Acute Pulmonary Edema
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Exophthalmic Goitre
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? no test possible
(Signed) S Hopper, M. D.
12-29, 1930 (Address) Hazelton

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls
Date of Burial Dec 30 1930
20. Undertaker White Mortuary
Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73255

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 1
Primary Registration District No. 18 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

131

2. FULL NAME Nancie C. Millsaps

RECEIVED JAN 9 1931

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX D.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 29/1870

7. AGE Years 60 Months 4 Days 21 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maysville W. Virg.

PARENTS
10. NAME OF FATHER C. C. Burgess
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maysville West Va.
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or County) West Virginia

14. Informant (Address) J. C. Millsaps

15. Filed 12/20, 1930 C. F. Zeller Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1930, 19, to Dec. 18, 1930
that I last saw her alive on Nov., 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cardio Vascular Renal disease

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Heart failure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. F. Zeller, M. D.
12/20, 1930 (Address) Jerome

19. Place of Burial, Cremation, or Removal Jerome, Ida. Date of Burial 12/21 1930

20. Undertaker D L Herisson Address Jerome, Ida.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1355

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Sylvian George Roots

(a) Residence. No. ..... St. 1013
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Shoshone Idaho
(State or country)

PARENTS

10. NAME OF FATHER James C Roots

11. BIRTHPLACE OF FATHER (city or town) Colo
(State or Country)

12. MAIDEN NAME OF MOTHER Gladys May Bell Rogers

13. BIRTHPLACE OF MOTHER (city or town) Colo
(State or County)

14. Informant James C Roots
(Address) Jerome Idaho

15. Filed 12/18, 1930 Chas F Zeller Jr Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 16 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16, 1930, to Dec 16, 1930
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) C. P. Zeller, M. D.
12/18, 1930 (Address) Jerome, Ida

19. Place of Burial, Cremation, or Removal: Twendell, Ida — Date of Burial: 12/18 1930

20. Undertaker: D. L Henderson — Address: Jerome, Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1320

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

162

RECEIVED JAN 9 '31

2. **FULL NAME** James Wilson Conklin
(a) Residence No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	W	—

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec. 21 / 30

7. AGE	Years	Months	Days	If LESS than 1 day,
			2 1/2	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Jerome, Ida

PARENTS
10. NAME OF FATHER Robt Conklin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nev
12. MAIDEN NAME OF MOTHER Mary M. Wilson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Hansen

14. Informant Robt Conklin
(Address) .....

15. Filed 12/24/, 1930 C. E. Zeller Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1930 to Dec. 23, 1930
that I last saw h.. in alive on Dec. 23, 1930
and that death occurred, on the date stated above, at 10 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Haemolytic Infant
Knotting of cord in utero
with partial obstruction of
circulation (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) C. E. Zeller, M. D.
12/24, 1930 (Address) .....

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Jerome, Ida	
20. Undertaker	Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPA

State File No. 73258

PLACE OF DEATH

County of Jerome

City of Jerome

Registration District No. 18

Primary Registration District No.

Local Registrar's No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

90

JAN 9 193

2. FULL NAME Dewey Ray Lowe

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6. DATE OF BIRTH (month, day and year)

7. AGE Years 3 Months 0 Days 14 If LESS than 1 day, ✓ hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Jerome Idaho

PARENTS

10. NAME OF FATHER Jas. S Lowe

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mabel Mason

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Utah

14. Informant Father

(Address) Jerome Idd

15. Filed 12/17, 1930 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 16, 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dead when I was Calle, to 19

that I last saw h alive on 19

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Some form of heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Died at once no

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Victory of disease

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sam F Price, M. D.

Dec. 17, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Jerome Idaho

Date of Burial 12/17 19

20. Undertaker None

Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73259

PLACE OF DEATH
County of Jerome
City of Jerome
Registration District No. 18
Primary Registration District No.
Local Registrar's No.
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 9 1931

2. FULL NAME John Swanson
(a) Residence. No. Jerome Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Clovia Swanson

6. DATE OF BIRTH (month, day and year) Aug 14. 1847.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	3	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (City or town) (State or Country)

14. Informant C C Pharris.
(Address) Jerome, Idaho.

15. Filed 12/5, 1930 Chas. E. Zeller. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 5 .1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1930, to Dec. 5, 1930
that I last saw h alive on 4:30 P.M. 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Dropsy & Oedema
Lungs (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. E. Zeller, M. D.
, 19 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise, Idaho	Dec 6 1930
20. Undertaker	Address
J. E. Drake	Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73262

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene — Burnyside —
Registration District No.
Primary Registration District No.
Local Registrar's No. 172

(No. 128)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Janeine Kristina Christensen.

RECEIVED JAN 8 1931

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	married

5a. If married, widowed, or divorced
~~HUSBAND~~ of (or) WIFE of Jacob Christensen

6. DATE OF BIRTH (month, day and year) 1857 - 9 - 30

7. AGE	Years	Months	Days	If LESS than 1 day,
	73	2	11	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Christian Pallesen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Rodell Petersen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Geo Christensen.
(Address)

15. Filed 12 - 29, 1930 N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1930, to Dec. 10, 1930
that I last saw h[er] alive on Dec. 10, 1930
and that death occurred, on the date stated above, at 1045 P. m.
The CAUSE OF DEATH* was as follows:

Nephritis acute. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis

(Signed) J. C. Owen, M. D.
Dec 11, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem CDAlene	12-16 1930
20. Undertaker	Address
Carsedy Funeral Home	CDAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

S. F. No. 825—1921. Approved as to Form by Dept. of Efficiency. 8926.

Washington State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. ~~2-2-83~~ 73203

Registered No. 173

1. PLACE OF DEATH

County of ~~Spokane~~ Kootenai

City or Town of ~~Spokane~~ Athol Ida.

Registration Dist. No. 30 No. Athol St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

1880 RECEIVED JAN 8 1931

2. FULL NAME Mrs. Mary Porter

(a) Residence: No. E. 424 Montgomery St., Ward. Spokane, Wash.

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of L.E. Porter

6. DATE OF BIRTH (month, day, and year) Oct 13 –

7. AGE Years 60 Months Days If LESS than 1 day, ...hrs, or....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Santa Rosa California

FATHER

13. NAME Caskey

14. BIRTHPLACE (city or town) (State or country) not obtainable

MOTHER

15. MAIDEN NAME not obtainable

16. BIRTHPLACE (city or town) (State or country) not obtainable

17. INFORMANT (Address) 621 E 24th Mrs Harry Chisholm

18. BURIAL, CREMATION, OR REMOVAL Place Greenwood Date Dec 11, 1930

19. UNDERTAKER (Address) Turnbull-Murphy 615 W. 4th Ave

20. FILED 12-29, 1930 H. J. Sturges Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) 12-8-1930

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

I last saw her alive on ....., 19...., death is said to have occurred on the date stated above, at ....m.

The principal cause of death and related causes of importance in order of onset were as follows: Coroner Case

	Date of onset
Fractured Cervical Vertebrae - due to R.R. accident at Athol Ida.	

Contributory causes of importance not related to principal cause:

Name of operation ..... Date of .....

What test confirmed diagnosis? Clinical Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? accident Date of injury 12-8-1930

Where did injury occur? Athol Idaho. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. on R.R.

Manner of injury R.R. accident.

Nature of injury Fractured Cerv. Vertebrae.

24. Was disease or injury in any way related to occupation of deceased? No.

If so, specify Signature at request of Mr. Mooney of Coeur d'Alene Ida. Coroner, M. D.

(Signed) (Address) T. E. Barnhart Coroner of Spokane Co. Wn.

Dr. Barnhart.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73264

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 170

(No. 1110) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Edgar C. Scribner

(a) Residence. No. 918 Foot Way St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1895, 2-12

7. AGE	Years	Months	Days	If LESS than 1 day,
	35	10	4	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maine Minn

PARENTS

10. NAME OF FATHER Albert E. Scribner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Annie Rollingstone
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wis

14. Informant C. Clarence Scribner
(Address) Great Falls Mont

15. Filed 12-29, 1930. N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 16 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4th, 1930, to Dec. 16, 1930
that I last saw h~~s~~e alive on Dec 16, 1930
and that death occurred, on the date stated above, at 12:35 P m.
The CAUSE OF DEATH* was as follows:

Post Operative for peptic Ulcer

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis Ch.

(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Coeur d'Alene, Idaho
Did an operation precede death? Yes Date of 12-11-30
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Harold J. Sturgess, M. D.
12-20, 1930 (Address) CdA Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CdAlene	12-20 1930
20. Undertaker	Address
Cassedy Funeral Home	CdAlene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Wooley, Ida.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1050

(No. ..... St.)

File No. 171

Registered No. 73265

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amons Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Sep. (Month) 24 (Day) 1860 (Year)

7. AGE: 70 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Vioka, Wisconsin

10. NAME OF FATHER: Chas Wright

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Deborah Oliver

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Harry Peck

(Address) E 418 - 5th Ave Spokane

15. Filed 12-29 1930

H. J. Sturger
Local Registrar

MEDICAL CERTIFICATE OF DEATH

RECEIVED JAN 8 1931

16. DATE OF DEATH: Dec 14a (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from He had No attendant to ..... 19....

that I last saw h..... alive on Saw him Dead Dec 17-10 A.M. 1930

and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senile Decay

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennington M. D.

..... 19.... (Address) Wooley, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash

DATE OF BURIAL: Dec 19 1930

20. UNDERTAKER: Turnbull & Merager

ADDRESS: 615 W - 4th

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73266

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 174

43

RECEIVED JAN 8 1931

2. FULL NAME Van Millison
(a) Residence. No. 1130 — 6th St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Millison

6. DATE OF BIRTH (month, day and year) June 29, 1884

7. AGE Years 46 Months 5 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wisc

PARENTS
10. NAME OF FATHER Levi Millison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary Dousch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant Mrs Nettie Millison
(Address) Coeur d'Alene Idaho

15. Filed 12/29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 3 P.M. m.
The CAUSE OF DEATH* was as follows:
Cancer of Face
(No Medicall attendance)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) R. B. Mooney Coroner, M. D.
12/29, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Forest Cemetery
Date of Burial 12/31 1930

20. Undertaker R. B. Mooney
Address Coeur d'Alene

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13267

PLACE OF DEATH
County of Kootenai
City of Hayden Lake

Registration District No. 30
Primary Registration District No. 1050

Local Registrar's No. 176

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 1931

2. FULL NAME Jas Gunn

(a) Residence. No. 45 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Gunn

6. DATE OF BIRTH (month, day and year) 1868 5-30

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10. NAME OF FATHER Donald Gunn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Margaret Murrey
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Scotland

14. Informant J. L. Murrin
(Address) Coeur d'alene Ida.

15. Filed 12/29, 1930 N. J. Sturgess Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 26, 1930
that I last saw him alive on Dec 26 1930
and that death occurred, on the date stated above, at 8:00 A. m.
The CAUSE OF DEATH* was as follows:
Carcinoma-Generalized over abdomen.
(duration) ..... yrs. 2 mos. ..... ds.
CONTRIBUTORY (Secondary) Ca. of stomach-Primary
(duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted, if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Signs
(Signed) D. K. Stone M. D.
Dec 29, 1930 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. C'Dalene	12-30-1930
20. Undertaker	Address
Carney Funeral Home	C'Dalene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7326

PLACE OF DEATH
County of Kootenai
City of Post Falls
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 175
(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 1931

2. FULL NAME Alice Lillian Martin
(a) Residence. No. Post Falls, Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 15, 1862

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10. NAME OF FATHER Frederick Post
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Margeret Hildt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Julia Martin
(Address) Spokane, Wn.

15. Filed 12-29, 1930 H. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Dec 25, 1930 that I last saw her alive on Dec. 24, 1930 and that death occurred, on the date stated above, at about 6 A. m.

The CAUSE OF DEATH* was as follows:

Internal injury sustained from auto accident and acute Bronchitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms

(Signed) F. L. McCauley M. D.
Dec 27, 1930 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Post Falls Cemetery	12/ 1930

20. Undertaker R. B. Mooney Address Coeur d'Alene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7320

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 177

(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 1931

2. FULL NAME Elizabeth E. Kibler

(a) Residence. No. 1006 - 11. 4th St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

129

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Aaron Kibler

6. DATE OF BIRTH (month, day and year) 1842 - 8-23

7. AGE — Years 88 | Months 4 | Days 3 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Butler Co. Penn.

PARENTS

10. NAME OF FATHER Wm McCandless
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Anna Luse
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn.

14. Informant J. H. McCandless
(Address) Clarkston, Wash.

15. Filed 12-29-, 1930 W. J. Sturgeon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1930, to Dec 24, 1930
that I last saw her alive on Dec 24, 1930
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) E. H. Teed M. D.
12-29-, 1930 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest Cem. CDalene	12-29 1930
20. Undertaker	Address
Cassedy Funeral Home	CDalene

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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4k

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7327

PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
Registration District No. 30
Primary Registration District No. 1050
Local Registrar's No. 178

(No.) (If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 8 1931

2. FULL NAME A. Olivia Hoffman

(a) Residence. No. 1322 - 9th St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Claude Hoffman

6. DATE OF BIRTH (month, day and year) 1887-5-7

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	7	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Stillwater Minn.

PARENTS

10. NAME OF FATHER John G. Swanson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Carrie Swanson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Claude Hoffman
(Address) 1322 - 9th

15. Filed 12-29, 1930 W. J. Sturges Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1928, to December, 1930
that I last saw h[illegible] alive on December 26, 1930
and that death occurred, on the date stated above, at 9.30 A. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease.
(duration) 2 yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) General anasarca.
(duration) 1 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Alexander Barclay, M. D.
Dec 27 - 1930 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Forest-Cem. CdAlene	12-28 1930
20. Undertaker	Address
Cassady Funeral Home	CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73271

PLACE OF DEATH
County of Latah
City of Harvard

Registration District No. 6J
Primary Registration District No. 2145
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

1000

2. FULL NAME Frank H. Peterson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Bessie

6. DATE OF BIRTH (month, day and year) June 8-1896

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	6	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Harvard Idaho

PARENTS

10. NAME OF FATHER Otto B. Peterson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Chicago Ill

14. Informant Bessy Peterson
(Address)

15. Filed Dec. 13th, 1930 D. J. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 11 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 - 1930, to Dec 10 1930
that I last saw him alive on Dec 10 - 1930
and that death occurred, on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Severe Cold

(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination

(Signed) F. C. Peterson, M. D.
Dec 11 - 1930 (Address) Potlatch Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Gr. Anderson. Palouse Wash	Dec. 14 1930
20. Undertaker	**Address**
E. Anderson.	Palouse

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73272

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Latah
City of Viola

Registration District No. 65
Primary Registration District No. 3145 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** James Fredrick Libey

(a) Residence. No. ..... St. 1010
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 11 - 1852

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	2	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Perry County Indiana

PARENTS

10. NAME OF FATHER George Libey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Nat Knowd

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) H. P. Libey Viola Ida

15. Filed Nov 25th, 1930 D. J. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 22 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Nov 22, 1930, that I last saw him alive on Nov 20 - 1930 and that death occurred, on the date stated above, at 9:20 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Croupous pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) F. C. Gibson, M. D.
Nov 25, 1930 (Address) Bovill

19. Place of Burial, Cremation, or Removal: Viola Ida — Date of Burial: Nov 25 1930

20. Undertaker: E. M. Lewis — Address: Palouse Wash

FORM V. S. No. 5-25-M. 1-19. DEC 29 1930

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Pottatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... , ... St.)

File No. 73273

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Phillips Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 12th (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles E. Clark

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Sadie H. Mooney

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E. Clark

(Address) Pottatch

15. Filed Nov 17th 1930 D J W Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 162

Nov (Month) 15th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12th 1930, to Nov 15th 1930 that I last saw him alive on Nov 15th 1930 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Inanition

..... (Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J. W. Thompson M. D.

11/17/ 1930 (Address) Pottatch

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pottatch Cemetery

DATE OF BURIAL: Nov 15th 1930

20. UNDERTAKER: Parents

ADDRESS: Pottatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED DEC 29 1930

DO NOT WRITE IN THIS SPACE
State File No. 73274

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No. ....
(No. ....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John H. Yates 110

(a) Residence. No. .... St. ....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Flora Yates

6. DATE OF BIRTH (month, day and year): 1868

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
72	4	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber
(c) Name of employer: Potlatch Lumber Co

9. BIRTHPLACE (city or town) (State or country): Ogden Ill

PARENTS

10. NAME OF FATHER: William F. Yates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Paper
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Indiana

14. Informant (Address): D. M. Yates 2608 39th West Seattle

15. Filed 12/24/, 1930. J. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-9th, 1930, to Dec-23rd, 1930, that I last saw him alive on Dec. 23rd, 1930, and that death occurred, on the date stated above, at .... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Emphysema. following Influenza.

.... (duration) .... yrs. .... mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

.... (duration) .... yrs. .... mos. .... ds.

18. Where was disease contracted if not at place of death? ....
Did an operation precede death? yes Date of Dec. 18th
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) J. W. Thompson, M. D.
12/24/, 1930 (Address) Potlatch

19. Place of Burial, Cremation, or Removal: Potlatch Idaho — Date of Burial: Dec 27 1930

20. Undertaker: E Anderson — Address: Clarkston

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. T3275

REC'D DEC 29 1930

PLACE OF DEATH
County of Latah
City of Near Viola
Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Wilford James Lyington
(a) Residence. No. Hornford St. Idaho
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

1880

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28	10	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Milton Becker Nelson B.C.

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER William Gunton
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Francis Harris
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Moosejaw Canada

14. Informant Harold N. Gunton
(Address) 533 Oneida St Medford Ore.

15. Filed Dec. 22, 1930 J. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw him ✓ alive on ✓, 19...
and that death occurred, on the date stated above, at ... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Automobile accident from defective lights ran off grade crushed injury & Brain.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ✓
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) J. W. Thompson M. D.
12/22/, 1930 (Address) Kendrick

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash	Dec 27 1930
20. Undertaker E Anderson	Address Clarkston Wn

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73276

PLACE OF DEATH
County of Latah
City of Onaway

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Falby Jane Gorton

(a) Residence. No. St. 8813
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E Gorton

6. DATE OF BIRTH (month, day and year) Oct 21 — 1880

7. AGE Years 50 Months 1 Days 9 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Fall River
(State or country) Kansas

PARENTS
10. NAME OF FATHER Joseph Vanhorn
11. BIRTHPLACE OF FATHER (city or town) Not known
(State or Country)
12. MAIDEN NAME OF MOTHER Baier
13. BIRTHPLACE OF MOTHER (city or town) Not known
(State or County)

14. Informant (Address) S. Gorton, Onaway Ida

15. Filed Nov 31st, 1930 Dr J. W. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 30 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1930, to Nov. 30, 1930
that I last saw her alive on Nov. 30, 1930
and that death occurred, on the date stated above, at 5 45 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with Decompensation

(duration) Questionable yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Hyden Hancher, M. D.
Dec 1, 1930 (Address) Potlatch - Idaho

19. Place of Burial, Cremation, or Removal Palouse Nash
Date of Burial Dec 2 1930

20. Undertaker E Anderson
Address Clarkston Wn

DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73277

PLACE OF DEATH
County of Latah
City of Harvard

Registration District No. 65
Primary Registration District No. 2145

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

48B

2. FULL NAME Nels. Johnson

(a) Residence. No. Harvard St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Johnson

6. DATE OF BIRTH (month, day and year) 1851

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79.	2.		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Farming
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Sweeden

PARENTS

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweeden

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweeden

14. Informant Martin J. Johnson
(Address) Harvard Idaho

15. Filed Dec. 3rd, 1930 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan., 1930, to Dec., 1930, that I last saw ~~him~~ alive on June, 1930, and that death occurred, on the date stated above, at 5-4 m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of ✓
Was there an autopsy? ✓
What test confirmed diagnosis? ✓

(Signed) J. W. Thompson, M. D.
Dec. 3rd, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Palouse Wash.	Dec. 5th 1930
20. Undertaker E. Irwin	Address Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73278

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No.
Primary Registration District No.
(No.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Eduard Martin. 1010

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Jessie Myrtle Martin.

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Lumber Mill
(c) Name of employer Potlatch Lumber Co.

9. BIRTHPLACE (city or town) (State or country) Oregon

PARENTS
10. NAME OF FATHER Norman Martin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Caroline McClain
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) U.S.

14. Informant Mrs. Jessie Martin
(Address) Potlatch Idaho.

15. Filed Dec. 25, 1930 J. W. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 25th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23rd, 1930, to Dec. 25th, 1930
that I last saw ~~him~~ alive on Dec. 25th, 1930
and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:

Croupous Pneumonia.
(duration) yrs. mos. 3. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) T. C. Enderson, M. D.
Dec. 25th, 1930 (Address) Potlatch

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Thornton Wash	Dec 28 1930
20. Undertaker E Enderson	Address Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 12321

PLACE OF DEATH
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No.) 74 W
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME ERNEST ANSON JONES

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edith Jones

6. DATE OF BIRTH (month, day and year) Mar 29, ~~1870~~ 1858

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.	8	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Mayesville
(State or country) Iowa

PARENTS

10. NAME OF FATHER A. Jones
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ind.
12. MAIDEN NAME OF MOTHER Zibia Evans
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ind

14. Informant Herman Jones
(Address) Potlatch Idaho.

15. Filed Dec. 4th, 1930 D. J. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 3, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 30, 1930, to Dec. 3, 1930
that I last saw him alive on Dec 3, 1930
and that death occurred, on the date stated above, at 1:00 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 3 ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) Hyden Hancher M. D.
Dec 5, 1930 (Address) Potlatch-Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow Idaho	12/5/30

20. Undertaker	Address
R. M. Grim	Moscow, Ida

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73289

PLACE OF DEATH

County of Latah
City of Potlatch
Registration District No. 65
Primary Registration District No. 7145
(No. Western Hospital Association Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)
Local Registrar's No.

2. FULL NAME Lora Ellen Martin

(a) Residence. No. 41 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Floyd Martin

6. DATE OF BIRTH (month, day and year) Dec 21 - 1902

7. AGE: Years 28 | Months 6 | Days 11 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garfield Washington

PARENTS
10. NAME OF FATHER Chas C Powell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Jessie Larkin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Garfield Wash

14. Informant Lorie A Farnam
(Address) Potlatch Idaho

15. Filed July 3 - 1930 J. Jr. Thompson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1930, to July 2, 1930
that I last saw h[er] alive on July 2, 1930
and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:
Septicemia - from Septic Sore throat (Ludwigs Angina) (Streptococcic throat) (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Chr. Tonsillitis for years. (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Hylla Hancher, M. D.
, 19 (Address) Potlatch, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Garfield Wash — Date of Burial: July 3 1930

20. Undertaker: E. W. Ervin — Address: Palouse Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 4328

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
(No.)
Local Registrar's No. 57
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME JAMES ALFRED LONG

(a) Residence. No. 41 St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mattie Long

6. DATE OF BIRTH (month, day and year) May 16, 1876

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	7	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Purdy
(State or country) Mo.

PARENTS

10. NAME OF FATHER F. H. Long
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Emiline Reed
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) MO.

14. Informant Mrs. J. A. Long
(Address) Moscow Idaho

15. Filed 12/23, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21, 1930, to Nov 1, 1930
that I last saw him alive on Nov 1, 1930
and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:
Streptococcus infection.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Compound comminuted fracture -both legs.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Oct 27-30
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Chas. L. Gatiens, M. D.
11/7/30, 19 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	11/4 1930
20. Undertaker F. R. Short	Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

RECEIVED DEC 2 5 1930

PLACE OF DEATH

County of Latah

City of Moscow

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 101

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. [illegible]

Local Registrar's No. 58

2. FULL NAME KATHERINE COMSTOCK 44

(a) Residence. No. .... St. ....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Comstock

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
76	3	2	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Columbus, (State or country) Ohio

PARENTS

10. NAME OF FATHER Paulus

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12. MAIDEN NAME OF MOTHER Erehardt

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Frank ComStock

(Address) Moscow Idaho

15. Filed 12/23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 3 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd, 1930, to Nov. 3, 1930

that I last saw her alive on Nov 3rd, 1930

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows: Gastric Ca. & Hepatic Metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral disease

(duration) some yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Analysis Gastric Contents, X-ray

(Signed) [signature] M. D.

11/7, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	11/7 1930
20. Undertaker	Address
[illegible]	Moscow

RECEIVED DEC 23 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73282

PLACE OF DEATH
County of Latah
City of Moscow,

Registration District No. 61
Primary Registration District No. 1011
(No.) 580
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 59

2. FULL NAME Mary L. Milton
(a) Residence. No. St. Troy Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) M.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Milton

6. DATE OF BIRTH (month, day and year) April 12 1876

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS
10. NAME OF FATHER Gustave Carlson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Sweden
12. MAIDEN NAME OF MOTHER Anna
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Sweden

14. Informant Carl Milton
(Address) Troy Ida

15. Filed 12/23, 1930 J. Harry Einhouse Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1928, to Nov 13, 1930
that I last saw her alive on Nov. 13, 1930
and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:
Pernicious anemia
(duration) 2½ yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only.
(Signed) C. D. Armstrong M. D.
Nov. 13, 1930 (Address) Moscow, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Troy Ida. Date of Burial Nov 16 1930

20. Undertaker John J Pickerd, Address Troy, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73284

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 61

(No.) 74B
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME BESSIE BERNADINE SCRENSON

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lee Screnson

6. DATE OF BIRTH (month, day and year) Nov. 5, 1907

7. AGE	Years	Months	Days	If LESS than 1 day,
	23	0	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Kendrick Idaho

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER John L. Woody
11. BIRTHPLACE OF FATHER (city or town) (State or Country) North Carolina
12. MAIDEN NAME OF MOTHER Martha Baldin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington

14. Informant John Woody
(Address) Moscow Idaho

15. Filed 12/23/30, 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 5, 1930 (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1930, to Nov. 5, 1930
that I last saw her alive on Nov. 4, 1930
and that death occurred, on the date stated above, at 2:10 P m.
The CAUSE OF DEATH* was as follows:

Embolism in brain

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute endocarditis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gotwalt, M. D.
11/6/30, 19 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
American Ridge Cemetery	11/8 1930
20. Undertaker	Address
F. R. Short	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73285

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 61

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

88B

2. FULL NAME Chris Christoffers

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 16, 1866

7. AGE Years: 64 Months: 11 Days: 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10. NAME OF FATHER: Hans Christofferson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Jackbson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Denmark

14. Informant: Ruth Mortenson

(Address) Moscow, Idaho

15. Filed 12/23, 30 Harry Einhorn Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 11/ 1930 19..... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

Found dead in his home.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. Short Coroner, ~~M.D.~~

11/15/ 30 19..... (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow — Date of Burial: 11/16 1930

20. Undertaker: H. R. Short — Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73286

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011

Local Registrar's No. 62

(No. 49)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susan M. Albright

(a) Residence. No. ..... St. Residence Dayton Wn.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 24 1843

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
87	5	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10. NAME OF FATHER J. W. Shivey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Lydia Epley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Don't Know

14. Informant E. J. Albright
(Address) Dayton, Wash.

15. Filed 12/2 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 11 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 11, 1930
that I last saw h[illegible] alive on Nov. 9, 1930
and that death occurred, on the date stated above, at 12 midnite
The CAUSE OF DEATH* was as follows:
Cellulitis of R. Leg.
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Carcinoma of liver.
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only.
(Signed) C. Armstrong, M. D.
Nov. 12, 1930 (Address) Tyhee Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Dayton Cemetery	Nov. 14 1930

20. Undertaker	Address
G. R. Rogg	Dayton, Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

very item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC

PLACE OF DEATH

County of Latah

City of Moscow

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 73[illegible]

Local Registrar's No. 63

88B

2. FULL NAME David L. Weeks

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliaabeth Weeks

6. DATE OF BIRTH (month, day and year): Jan. 2, 1851

7. AGE: Years 79, Months 10, Days 11. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Floyd County Vir.

PARENTS

10. NAME OF FATHER: Robert Weeks

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Vir.

12. MAIDEN NAME OF MOTHER: Mary Houchgin

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Vir.

14. Informant: E.D. Weeks

(Address): Moscow, Ida.

15. Filed 12/23, 1930. [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 13, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19 ..., to Nov. 13, 1930

that I last saw him alive on November 13, 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary): Carcinoma Stomach.

..... (duration) 1 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical only.

(Signed) [signature], M. D.

11/14, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow

Date of Burial: 11/16/30 19

20. Undertaker: H. R. Short

Address: Moscow

RECEIVED DEC 2 5 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73283

PLACE OF DEATH

County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 10 11
(No. 127)
Local Registrar's No. 64

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME George Washington Flieger

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 6, 1928

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
2	6	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Moscow, Idaho

PARENTS

10. NAME OF FATHER L.C. Flieger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis.
12. MAIDEN NAME OF MOTHER Hattie Allen
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Moscow, Ida.

14. Informant L.C. Flieger
(Address) Moscow, Ida.

15. Filed 12/23, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 14/ 1930
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov 9, 1930, to Nov 14, 1930
that I last saw him alive on Nov 13, 1930
and that death occurred, on the date stated above, at one p m.
The CAUSE OF DEATH* was as follows:

Malnutrition with acute Gastritis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

since birth (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Palpation & Symptoms

(Signed) Dr E J Call M.D.
11/17, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	11/17/30

20. Undertaker H. R. Short — Address Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 2 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73289

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 65
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Winfield Scot Dennison 128
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ida Dennison

6. DATE OF BIRTH (month, day and year)

7. AGE Years 78 Months 9 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER William Dennison
11. BIRTHPLACE OF FATHER (city or town) (State or Country) New York
12. MAIDEN NAME OF MOTHER Eleanor Gawry
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Pennsylvania

14. Informant (Address) Earl Thomas Denison Pottatoh Ida

15. Filed 12/23, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11th, 1930, to Nov 16, 1930
that I last saw him alive on Nov 16, 1930
and that death occurred, on the date stated above, at 6 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Interstitial nephritis

Dont Know (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Dont Know
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical evidence
(Signed) F. M. Leitch, M. D.
11/19, 1930 (Address) Moscow Idaho

19. Place of Burial, Cremation, or Removal Pottatoh Ida
Date of Burial Nov 19 1930

20. Undertaker F M Irwin
Address Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED DEC 2 0 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7329

PLACE OF DEATH

County of Latah

City of Moscow (rural)

Registration District No. 61

Primary Registration District No. 1911

Local Registrar's No. 66

(No. 880)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Berchie Nathen Wilson

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 12/ 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51		11	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farm hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Hastings , Neb.

PARENTS

10. NAME OF FATHER James Wood

11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER M.A. Wilson

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs. Geo. C. Miller

(Address) Moscow, Idaho

15. Filed 12/5, 30 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH #9 Nov. 23, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1929, to Nov 23, 1930

that I last saw him alive on Nov. 15, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis.

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C Olmsted, M. D.

11/24, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	11/25/30

20. Undertaker	Address
H.R. SHORT	MOSCOW

RECEIVED DEC 26 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73291

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. Gritman Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 67

109 b

2. FULL NAME John Nicholas Friedman Jr.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 25, 1906

7. AGE: Years 24 | Months 5 | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Bakers helper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Moscow
(State or country) Idaho

PARENTS

10. NAME OF FATHER John N. Friedman
11. BIRTHPLACE OF FATHER (city or town) Ohio
(State or Country)
12. MAIDEN NAME OF MOTHER Margaret McGarr
13. BIRTHPLACE OF MOTHER (city or town) Iowa
(State or Country)

14. Informant J.N. Friedman
(Address) Moscow, Ida.

15. Filed 12/23, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 25, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1930, 19, to Nov. 25, 1930
that I last saw him alive on Nov. 25, 1930
and that death occurred, on the date stated above, at 1:15 A. m.
The CAUSE OF DEATH* was as follows:

Peritonsillar abcess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia.

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. L. Gritman, M. D.
11/26, 30 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 11/28/30

20. Undertaker: H. R. Short
Address: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 13293

1. PLACE OF DEATH
County of Latah
City of Genesee Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Rebecca Steele

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 18 (Day) 1925 (Year)

7. AGE: 5 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Latah County Idaho. 7 Miles West of Genesee Idaho

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Cecelia Sophia Sprenger

13. BIRTHPLACE OF MOTHER (State or Country): Latah County Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Sprenger
(Address) Genesee Idaho

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1930, to Dec 23 1930 that I last saw her alive on Dec 23 1930, and that death occurred on the date stated above, at 9:00 M.

The CAUSE OF DEATH* was as follows:

Epilepsy. Grand Mal.

(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Walter A. Berry M. D.

Dec 24 1930 (Address) Uniontown Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? —
Former or usual residence: 7 Miles West of Genesee Idaho

19. PLACE OF BURIAL OR REMOVAL: Genesee Cemetary
DATE OF BURIAL: 12/26 1930

20. UNDERTAKER: Glen A. Love, Genesee Idaho
ADDRESS: Lewiston Idaho
Vaccs. Undertaking Parlors

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73394

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Latah
City of Deary

Registration District No. 64
Primary Registration District No. 2144
(No. .....)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Swan Erickson

(a) Residence. No. ..... St. 749
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): May date not Known -1862

7 AGE: Years 68 Months 7 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): own business
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sweden

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Peter Olson
(Address): Deary Idaho

15 Filed Dec 30, 1930 Lucy M Pickerd Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 28 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1930, to Dec 28, 1930, that I last saw him alive on Dec 28, 1930, and that death occurred, on the date stated above, at 7 20 p m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
immediate
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) Chas. A. Meyer M. D.
Dec 28, 1930 (Address) Troy, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Dry creek cem
Date of Burial: Jan 4 1930

20. Undertaker: John J. Pickerd
Address: Troy Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

DEC 20 1930

2-45 P.M.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 73295

Registered No. .....

1. PLACE OF DEATH. RE

Registration District No. 47

County of Lewis

Primary Registration District No. .....

City of Nezperce Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy A. Adams

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Jan 22 (Month) 1839 (Day) (Year)

7. AGE: 91 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Youngstown Ohio

10. NAME OF FATHER: Stephen Woodruff

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Duncan

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Florence Adams Johnson
(Address) Nezperce Ida.

15. Filed Nov 6 1930 Albert Hoff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 164
Sept (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on 30 1930,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) One Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce Cemetery	Dec 1 1930
20. UNDERTAKER	**ADDRESS**
Albert Hoff	Nezperce Idaho

SYMS - YORK CO., PTRS. & BORS. 24654

RECEIVED DEC 26 1930

PLACE OF DEATH

County of Latah

City of Russel Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 47

Primary Registration District No.

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

DO NOT WRITE IN THIS SPACE

State File No. 73296

Local Registrar's No. 155

2. FULL NAME George W. Wells

(a) Residence. No. 47 St.

(Usual place of abode)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 20 1849

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	10	8	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER George Wells

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12. MAIDEN NAME OF MOTHER — — —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) — — —

14. Informant Geo. W. Wells

(Address) Troy Idaho

15. Filed Nov 6, 1930 Albert Huff Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-27, 1930, to 10-27, 1930

that I last saw him alive on 10-27, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) 3 yrs. 0 mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) O.B. Pappenhagen, M. D.

10-28, 1930 (Address) Orofino Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rosalia Wash	Oct 30 1930

20. Undertaker	Address
Albert Huff	Moscow Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73297

PLACE OF DEATH
County of Lewis
City of Craigmont

Registration District No. 60
Primary Registration District No. 2129
Local Registrar's No. 23
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Scott Kelley
(a) Residence. No. St. 88 b
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct. 14 1855
7. AGE Years 75 Months 2 Days 5 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer. Retired
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant G C Agee
(Address) Craigmont, Ida.
15. Filed 12/20, 1930 J E Denney Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 19 30
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 9, 1925, to Dec 19, 1930.
that I last saw him alive on Dec 19, 1930
and that death occurred, on the date stated above, at 5:30 A. m.
The CAUSE OF DEATH* was as follows:
myocarditis
(duration) 6 yrs. mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? usual signs
(Signed) J. E. Denney M. D.
12-20, 1930 (Address) Craigmont

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal I O O F Cemetery Craigmont Ida
Date of Burial 12/20/30.
20. Undertaker Craigmont Hdwe Co
Address Craigmont

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73295

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2109
(No.)
Local Registrar's No. 22

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Velma Jeanet Smith 161a

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Baby.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years | Months | Days: 18 | If LESS than 1 day, 6 hrs. or 15 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Baby.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Winchester, Idaho

PARENTS

10. NAME OF FATHER: Warren Smith
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Melborn × Iowa.
12. MAIDEN NAME OF MOTHER: Edna Jameson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Nezperce, Ida

14. Informant: Warren A. Smith
(Address) Craigmont Ida

15. Filed Jan 7, 1931 R C Dwelle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1930, to Dec. 12, 1930
that I last saw her alive on Dec. 12, 1930
and that death occurred, on the date stated above, at 12:45 P m.
The CAUSE OF DEATH* was as follows: Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) R B Halliday, M. D.
12/12, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation or Removal: I.O.O.F. Cemetery Craigmont — Date of Burial: 12-13-1930
20. Undertaker: Craigmont Hdwe Co — Address: Craigmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73299

PLACE OF DEATH
County of Lewis
City of Winchester

Registration District No. 60
Primary Registration District No. 2129
Local Registrar's No. 21

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fredrick D. Nelson
(a) Residence. ~~No.~~ Reubens Idaho St. 88b
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 22 1850

7. AGE Years: 80 Months: 5 Days: 19 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs R. E. Tozier
(Address) Helix Ore.

15. Filed 12/17, 1930 R E Dunwell Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/6, 1930, to 12/11, 1930
that I last saw him alive on 12/11, 1930
and that death occurred, on the date stated above, at 3:00 A m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Old Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) A. B. Halliday, M. D.
12/11, 1930 (Address) Winchester, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Reubens
Date of Burial: 12-13 1930

20. Undertaker: Craigmont Hdwe Co
Address: Craigmont Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 20 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73300

PLACE OF DEATH

County of Lincoln
City of Richfield

Registration District No. 16
Primary Registration District No. 2016
Local Registrar's No. 23

(No.) 165
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joen Albert Newby

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 20 1909

7. AGE	Years	Months	Days	If LESS than 1 day,
	20	10	22	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work RR Section Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer O S L R R Co

9. BIRTHPLACE (city or town) (State or country) Herbert Idaho

PARENTS

10. NAME OF FATHER Nicholas Newby
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Lorinda Barber
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Salem Idaho

14. Informant Nicholas Newby
(Address)

15. Filed Dec 13, 1930 L L Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 27, 1930, to Nov 25, 1930
that I last saw him alive on Nov 25, 1930
and that death occurred, on the date stated above, at 8.30 A m.
The CAUSE OF DEATH* was as follows:
Arsenic Poisoning

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? State Chemist Report

(Signed) , M. D.
12/13, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Idaho	12-13 1930
20. Undertaker	Address
[illegible] Hackett	Shoshone

RECEIVED DEC 20 1930

73301

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1. PLACE OF DEATH

County Lincoln State IDAHO Registered No. 24

Township ..... or Village Shoshone or

City ..... No. ..... St., ... Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Chas Stewart Finlaysen 40

(a) Residence: No. ..... St., ... Ward. .....

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE: Years 64 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. No occupation

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Did odd jobs

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Ross Shire Scotland

FATHER

13. NAME Roderick Finlaysen

14. BIRTHPLACE (city or town) (State or country) Scotland

MOTHER

15. MAIDEN NAME Christiana Stewart

16. BIRTHPLACE (city or town) (State or country) Scotland

17. INFORMANT (Address) Frank Finlaysen Shoshone Idaho

18. BURIAL, CREMATION, OR REMOVAL Place Shoshone Ida Date 12-16, 1930

19. UNDERTAKER (Address) C. E. Hickok Shoshone Idaho

20. FILED Dec 16, 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) 12/14, 1930

22. I HEREBY CERTIFY, That I attended deceased from 12/14, 1930, to 12/14, 1930

I last saw him alive on 12/12, 1930; death is said to have occurred on the date stated above, at 12 30 P m.

The principal cause of death and related causes of importance were as follows: Acute Dilation of Heart, | Date of onset

Other contributory causes of importance: Hard work, and acute indigestion | 12/14/30

Name of operation ..... Date of .....

What test confirmed diagnosis? Death. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) [signature], M. D.

(Address) Shoshone Idaho

c11—3184

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 f
V. S. No. 98

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73302

PLACE OF DEATH
County of Lincoln
City of Richfield

Registration District No. 16
Primary Registration District No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 24

2. FULL NAME Mary Grace Stevens

(a) Residence. No. ..... St. 88b
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Walter Stevens

6. DATE OF BIRTH (month, day and year) May 22 1886

7. AGE: Years 44, Months 7, Days 5. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Fountain Green Utah

PARENTS
10. NAME OF FATHER: James F Crowther
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Mary Olson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: Walter Stevens
(Address)

15. Filed Dec. 30, 1930 J. L. Fuller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1930, to Dec 27, 1930
that I last saw her alive on Dec 27, 1930
and that death occurred, on the date stated above, at 10.30 A m.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Anasarca
..... (duration) 2 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? Phy Exam.
(Signed) F. E. Barrett, M. D.
12/29, 1930 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Shoshone Ida
Date of Burial: Dec 31 1930

20. Undertaker: C E Hickok
Address: Shoshone Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 1303

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Boundary
City of Bonners Ferry Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George S. Collins,

(a) Residence. No. St.
(If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Barbara Collins

6. DATE OF BIRTH (month, day and year) Aug. 19, 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	3	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER John Collins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky
12. MAIDEN NAME OF MOTHER Lucy Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant Mrs. G.S. Collins,
(Address) Bonners Ferry, Idaho.

15. Filed Nov. 30, 1930. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 29, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 8:45A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration
(Sudden Death)

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History
(Signed) Chas Bonnell Co. M. D.
Nov 30, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal: Paradise Valley Cemetery, Bonners Ferry — Date of Burial: Dec. 2, 1930
20. Undertaker: H.R. Crouch, Bonners Ferry, Ida — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED DEC 1 1930

DO NOT WRITE IN THIS SPACE
State File No. 13304

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No. 45
(No. Bonners Ferry Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Olin

(a) Residence. No. ..... St. Libby, Mont.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 8, 1903.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	5	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Cascade Investment Co.

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Wesley Olin

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Vermont.

12. MAIDEN NAME OF MOTHER Ann Ward

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Maine.

14. Informant Mrs. Merle Blanchard
(Address) Libby, Mont.

15. Filed Nov. 23, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1930, to Nov. 22, 1930, that I last saw h.. alive on Nov. 22 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the mesentery

(duration) yrs. 5 (?) mos. ds.

CONTRIBUTORY (Secondary) Teratoma of testicle

(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? Troy, Mont.
Did an operation precede death? Testicle Date of July 1930
Was there an autopsy? No.
What test confirmed diagnosis? History

(Signed) E. E. Fry, M. D.
Nov 23 1930. (Address) Bonners Ferry Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Libby, Mont.	
20. Undertaker H. R. Crouch	Address Bonners Ferry, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 14 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73305

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard Beck

(a) Residence. No. St. 1
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): Feb. 13, 1912

7. AGE: Years 18, Months 8, Days 29. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Meridian Idaho.

PARENTS

10. NAME OF FATHER: L.C.Beck,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lillian Jones

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: L.C.Beck,
(Address) Bonners Ferry, Idaho.

15. Filed Nov. 12, 1930. E E Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 11, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1930, to Nov. 11, 1930 that I last saw him alive on Nov. 11, 1930 and that death occurred, on the date stated above, at 1:P.M m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? 2

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Widal test.

(Signed) E E Fry, M. D.

Nov. 12 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida.

Date of Burial: Nov. 18, 1930

20. Undertaker: H.R.Crouch, Bonners Ferry, Idaho.

Address

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73306

PLACE OF DEATH
County of Boundary
City of Porthill
Registration District No. 79
Primary Registration District No. 2156
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert Lee Austin,

(a) Residence. No. 31 St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 20, 1902.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28		20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tractor driver &mechanic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Morristown, Tenn.

PARENTS

10. NAME OF FATHER John Austin,
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Rhoda Pinkston
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Tenn.

14. Informant John Austin,
(Address) Porthill, Idaho.

15. Filed Nov. 10, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 9, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23, 1930, to Nov 9, 1930
that I last saw him alive on Nov 8, 1930
and that death occurred, on the date stated above, at 7: A.M. m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) yrs. 11 mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Gangrene
(duration) yrs. mos. 7 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical & Laboratory Examination

(Signed) [signature], M. D.
Nov 10, 1930 (Address) Bonners Ferry Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Porthill, Ida.	Nov. 12, 1930.

20. Undertaker	Address
H.R. Crouch,	Bonners Ferry, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73367

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 77
Primary Registration District No. 2156
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

126

2. FULL NAME Charles Early.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 67 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Hospital Record
(Address)

15. Filed Nov. 4, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 3, 1930
that I last saw him alive on Nov. 2nd, 1930
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:
Peritonitis
(duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) Ruptured gall bladder
(duration) ..... yrs. ..... mos. 1 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? yes.
What test confirmed diagnosis? Autopsy.
(Signed) E. E. Fry, M. D.
Nov. 4, 1930 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. | Date of Burial: Nov. 6 1930

20. Undertaker: H. R. Crouch, Bonners Ferry | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73308

PLACE OF DEATH

County of Cassia
City of Malta

CERTIFICATE OF DEATH

Registration District No. 119
Primary Registration District No. 2198 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.) 100 a

2. FULL NAME Wendell Junior Bailey
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos 21 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): —

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6. DATE OF BIRTH (month, day and year) Dec 6th 1930

7. AGE: 0 Years: 0 Months: 0 Days: 21 — If LESS than 1 day, ✓ hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) Malta
(State or country) Cassia Co. Idaho.

PARENTS

10. NAME OF FATHER Wendell Jones Bailey.
11. BIRTHPLACE OF FATHER (city or town) North Ogden
(State or Country) Weber Co. Utah.
12. MAIDEN NAME OF MOTHER Bernice Emma Shaw.
13. BIRTHPLACE OF MOTHER (city or town) Paradise
(State or County) Cache Co. Utah.

14. Informant (Address) Wendell Jones Bailey.

15. Filed Jan 10, 1931 C. L. Sater Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 27th
Dec (Month) ~~28~~ 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Dec 27, 1930
that I last saw him alive on Dec 28, 1930
and that death occurred, on the date stated above, at 2 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) C. L. Sater M. D.
Jan 1, 1930 (Address) Malta Ida

19. Place of Burial, Cremation, or Removal: Malta Idaho — Date of Burial: Dec 27, 1930
20. Undertaker: D. E. Johnson — Address: Burley Ida

RECEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73309

PLACE OF DEATH

County of Cassia
City of Malta

CERTIFICATE OF DEATH

Registration District No. 119
Primary Registration District No. 2198 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100 a

2. FULL NAME Frank Paskett
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Jessie Paskett

6. DATE OF BIRTH (month, day and year) January 25, 1885

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	11	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Gen'l Farming
(c) Name of employer Self

9. BIRTHPLACE (city or town) (State or country) Grouse Creek Utah

PARENTS

10. NAME OF FATHER Phillip A. Paskett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Emma Richins
13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Jessie H Paskett

15. Filed Jan 10, 1931 C I Sater Registrar.

MEDICAL CERTIFICATE OF DEATH
Dec 28th 1930. 5 P.M.

16. DATE OF DEATH Dec (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 28, 1930
that I last saw him alive on Dec 28, 1930
and that death occurred, on the date stated above, at 5 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At place of death
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual
(Signed) C I Sater M. D.
Dec 31, 1930 (Address) Malta Idaho

19. Place of Burial, Cremation, or Removal Malta Idaho. Date of Burial Dec. 31 1930

20. Undertaker D. E. Johnson Address Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7331

PLACE OF DEATH
County of Lemhi
City of Salmon

CERTIFICATE OF DEATH
Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Leonard Roth Cummings
(a) Residence. No. Lemhi Idaho St. 749
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12th 1850

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	2	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10. NAME OF FATHER: Leonard Cummings
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Not known

14. Informant (Address): Edson A. Morris, Salmon Idaho

15. Filed Jan 13, 1931 Ora Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 24th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20, 1930, to Dec 24, 1930
that I last saw him alive on Dec 24, 1930
and that death occurred, on the date stated above, at 7 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(duration) about yrs. 30 mos. ds.

CONTRIBUTORY (Secondary)
Senile debility (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer M. D.
12/29, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 12-27" 1930

20. Undertaker: Mrs C Hoebler
Address: Salmon Idaho

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 7333

PLACE OF DEATH

County of Lemhi

City of Salmon Hot Springs

Registration District No. .....

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Richard M. Twist

(a) Residence. No. Salmon Idaho St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work County Patient
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) United States

PARENTS

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) Fred Braught Jr. Salmon Idaho

15. Filed ....., 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 23rd 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March, 1929, to Dec 22, 1930, that I last saw h.. alive on Dec 22, 1930, and that death occurred, on the date stated above, at 10-30 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) several years yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas F Hammond, M. D.

12/29/30 (Address) Salmon

19. Place of Burial, Cremation, or Removal	Date of Burial
Salmon Cemetery	12-24-1930
20. Undertaker	Address
Wm C Hackett	Salmon, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73313

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME W. A. Kirkwood 74 9
(a) Residence. No. Goldburg Idaho. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years about 73 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Saw Mill Man
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not known

14. Informant (Address) W. G. Mercer

15. Filed Jan 10, 1931 Clio Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 13rd, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 13, 1930
that I last saw him alive on Dec 13, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer M. D.
12/29, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal: Salmon Cemetery | Date of Burial: 12-14th 1930
20. Undertaker: Wm C Dobbler | Address: Salmon Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73314

PLACE OF DEATH
County of Lemhi
City of Lemhi, Ida.

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joy Naomi Harris 100 a
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 16th Oct. 1930

7. AGE Years | Months 2 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Salmon, Idaho
(State or country)

PARENTS
10. NAME OF FATHER Arthur David Harris
11. BIRTHPLACE OF FATHER (city or town) Lawton
(State or Country) Oklahoma
12. MAIDEN NAME OF MOTHER Marguerite Pugh
13. BIRTHPLACE OF MOTHER (city or town) Salmon
(State or County) Idaho

14. Informant Lemhi, Idaho
(Address) Arthur Harris

15. Filed Jan 10, 1931 Clio B. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 21st, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7-a- m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Wm C Doebler Coroner, ~~M.D.~~
12-21st, 1930 (Address) Salmon Idaho

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 12-22 1930

20. Undertaker Wm C Doebler
Address Salmon

6

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73315

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

12 b

2. FULL NAME Norman A. Howell
(a) Residence. No. Salmon City Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9-14-1911

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
19	2	29	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Day Labor
(c) Name of employer

9. BIRTHPLACE (city or town) Albion Idaho
(State or country)

PARENTS

10. NAME OF FATHER Ralph N. Howell
11. BIRTHPLACE OF FATHER (city or town) Snowville Ut.
(State or Country)
12. MAIDEN NAME OF MOTHER Eva Albertson
13. BIRTHPLACE OF MOTHER (city or town) Albion Ida.
(State or County)

14. Informant (Address) C. W. Neider. Salmon Idaho

15. Filed Jan 10, 1931 Vic Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 13 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Dec 13, 1930
that I last saw him alive on Dec 13, 1930
and that death occurred, on the date stated above, at 10.30 P.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute diffuse Peritonitis

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Gangrenous appendicitis
..... (duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of 12/13/30.
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas F Hammer, M. D.
12/29/30, 19..... (Address) Salmon

19. Place of Burial, Cremation, or Removal Salmon Cemetery
Date of Burial 12-16th 1930

20. Undertaker Jim C. Doebler
Address Salmon Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

CEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73316

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Lemhi
City of Salmon

Registration District No. 41
Primary Registration District No. 2116 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Janet Louise Beattie
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 2 mos. 15 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 26th 1930

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Salmon, Idaho

PARENTS
10. NAME OF FATHER James Kinneth Beattie
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salmon, Ida.
12. MAIDEN NAME OF MOTHER Lydia Bancroft
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Salmon, Ida.

14. Informant (Address) [illegible] Kinneth Beattie

15. Filed Jan 10, 1931 [illegible] Bellamy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 12 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1930, to Dec 12, 1930
that I last saw her alive on Dec 12, 1930
and that death occurred, on the date stated above, at 7:20 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Meningitis

..... (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia
..... (duration) ..... yrs. ..... mos. 10 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? .....
(Signed) F S Wright, M. D.
12/10, 1930 (Address) Salmon

19. Place of Burial, Cremation, or Removal: Salmon Cemetery
Date of Burial: 12-15th 1930

20. Undertaker: Wm C Hackler
Address: Salmon Idaho.

Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7331

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. ...)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 76

75

RECEIVED JAN 12 1931

2. FULL NAME Josephine Barthles

(a) Residence. No. ... St. ...
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12, 1854

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	6	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Sweden

PARENTS

10. NAME OF FATHER: Anderson
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Sweden

14. Informant: Art. Jessup
(Address) Moscow, Ida.

15. Filed 1-9, 1930 J. Harry Einhaus Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31st (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1930, to Dec 31, 1930
that I last saw her alive on 24 Dec 1930
and that death occurred, on the date stated above, at 7:30 a. m.
The CAUSE OF DEATH* was as follows:
Paralysis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) W. A. Adair, M. D.
1/2 ..., 1931 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Albion, Wash.
Date of Burial: 1/2/31 19
20. Undertaker: H. R. Short
Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Magee

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73318

PLACE OF DEATH
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011

Local Registrar's No. 75

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME James Abner Gossett

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Francis Gossett

6. DATE OF BIRTH (month, day and year) Aug. 15, 1845

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	4	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blue Grass County Ky.

PARENTS

10. NAME OF FATHER James Gossett
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Ben Gossett
(Address) Moscow, Idaho

15. Filed 1-9, 1931 Harry Erickson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 31, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930 to Dec 30, 1930
that I last saw him alive on Dec 30, 1930
and that death occurred, on the date stated above, at 8 A m.
The CAUSE OF DEATH* was as follows: Cardio-Vascular Disease

..... (duration) 3 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 6 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) E R Magee, M. D.
1/2, 1931 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	1/3/31

20. Undertaker H. R. Short
Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7331 9

Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 74

PLACE OF DEATH

County of Latah
City of Moscow
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Amy A. Zumhoff

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of W.F. Zumhoff

6. DATE OF BIRTH (month, day and year) Mar. 20, 1863

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	9	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Millville
(State or country) Iowa

PARENTS

10. NAME OF FATHER John Collins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Florida Parke
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant W.F. Zumhoff
(Address) Moscow

15. Filed 1-9, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to Dec 29 1930, that I last saw her alive on Dec 28, 1930 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:
Acute myocarditis
(Sudden)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic myocarditis
Cardiac Asthma
(duration) 10 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical only

(Signed) C.A. Armstrong, M. D.
1-4, 1931 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	1/4/31 19

20. Undertaker H.R. Short — Address Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73320

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 73
(No.) 88
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME James C'Connor
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine C'Connor

6. DATE OF BIRTH (month, day and year) July 23, 1856

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	5	1	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Worcester N.Y.

PARENTS

10. NAME OF FATHER James C'Connor Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Mary Brennan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant Geo. O'Connor
(Address) Moscow Ida.

15. Filed 1-9, 1931 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 24, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1930, to Dec 24, 1930
that I last saw him alive on Dec 24, 1930
and that death occurred, on the date stated above, at 4:00 A m.
The CAUSE OF DEATH* was as follows:

Myo carditis- chronic
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Interstitial nephritis
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C O Timothy, M. D.
12/26, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	12/27 1930
20. Undertaker F. R. Short	Address Moscow

Magee

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73321

PLACE OF DEATH
County of Latah
City of Moscow (rural)

Registration District No. 61
Primary Registration District No. 1011
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 72

88 RECEIVED JAN 12 1931

2. FULL NAME Lavina Hobart
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Hobart

6. DATE OF BIRTH (month, day and year): Feb. 15/1850

7. AGE: Years 80, Months 10, Days 1. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Indiana

PARENTS
10. NAME OF FATHER: James Lennington
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not known
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): " "

14. Informant: Ed Hobart
(Address): Lewiston, Idaho

15. Filed 1-9, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 16/ 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14, 1930 to Dec 15, 1930
that I last saw her alive on Dec 15, 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows: Myocarditis & Nephritis
..... (duration) ..... yrs. some mos. ..... ds.
CONTRIBUTORY (Secondary): Edema & Basal Pneumonia
..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
12/17, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow
Date of Burial: 12/18/30 19

20. Undertaker: H. R. Short
Address: Moscow

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Armstrong

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73[illegible]

PLACE OF DEATH

County of Latah

City of Moscow

Registration District No. 61

Primary Registration District No. 1011

Local Registrar's No. 71

(No. 88 b)

(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Hannah Elizabeth Dosh

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: George B. Dosh

6. DATE OF BIRTH (month, day and year): May 12, 1853

7. AGE: Years 77 | Months 7 | Days 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Lee county Iowa

PARENTS

10. NAME OF FATHER: Enos Puckett

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Mary Ann Marshall

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

14. Informant: Mrs. Pitt
(Address): Moscow, Ida.

15. Filed 1-9, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 16/ 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1930, to Dec. 16, 1930 that I last saw her alive on Dec 15, 1930 and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Chr. interstitial nephritis

(duration) 4 yrs. mos. ds.

18. Where was disease contracted if not at place of death? –

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) C. V. Armstrong, M. D.

12/17, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Moscow | Date of Burial: 12/18/30 19

20. Undertaker: H. R. Short | Address: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Latah

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7333

PLACE OF DEATH
County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1911
Local Registrar's No. 70
(No. County Home)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Benj. Pearson

(a) Residence. No. ____ St. ____ (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Pearson

6. DATE OF BIRTH (month, day and year) Nov. 16/ 1850

7. AGE	Years	Months	Days	If LESS than 1 day,
	80		29	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Not known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Mrs. Anna Pearson
(Address) Moscow, Idaho

15. Filed 1-9, 1931. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 15/ 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Dec 14, 1930
that I last saw him alive on Dec 14 15, 1930
and that death occurred, on the date stated above, at 2.30 A m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Don't Know (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical evidence

(Signed) F. M. Leitch, M. D.
12/16, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Removal to Harvard	12/16/30
20. Undertaker	Address
H. R. Short	Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10324

PLACE OF DEATH

County of Latah
City of Moscow
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 69
(No. 88 St.)
(If death occurred in a hospital or institution, give its name instead of street and number)

RECEIVED JAN 12 1931

2. FULL NAME Robert Bruce Thurston

(a) Residence. No. (Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June 12, 1870

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Near Netta wa Mich.

PARENTS

10. NAME OF FATHER E.P. Thurston
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich.
12. MAIDEN NAME OF MOTHER Sarah Currier
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) N.Y.

14. Informant Mrs. Geo Carter
(Address) Moscow

15. Filed 1-9, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 10, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1930, to , 19
that I last saw him alive on Dec. 10, 1930
and that death occurred, on the date stated above, at 6:00 p.m.
The CAUSE OF DEATH* was as follows:
Myocarditis chronic
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) 5 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical.
(Signed) [signature], M. D.
12/11, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Clinton Cemetery	12/13/30

20. Undertaker	Address
H. R. Short	Moscow

Gritman

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73325

PLACE OF DEATH
County of Latah
City of Moscow (rural)
Registration District No. 61
Primary Registration District No. 1011
Local Registrar's No. 68
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Mitilda Bourgois.

(a) Residence. No. 47 St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of WM. Bourguis

6. DATE OF BIRTH (month, day and year) Nov, 15, 1845

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85		16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Champlain N.Y.

PARENTS

10. NAME OF FATHER Falcon
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER " " " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " " " "

14. Informant Geo. C'Conner
(Address) Moscow, Idaho

15. Filed 1-9, 1931 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1930, to Dec 1, 1930
that I last saw her alive on Nov. 19, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Carcinoma of the breast.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas L. Gritman, M. D.
12/2/, 1930 (Address) Moscow

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow	12/3/30 19
20. Undertaker	Address
F. R. Short	Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Adams

City of Council

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 188

(No. ....., ... Str.)

RECEIVED JAN 12 1931

File No. 73326

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene Milton Wade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. March (Month) 9 (Day) 1915 (Year)

7. AGE 15 Yrs. 8 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Student

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ark.

10. NAME OF FATHER Edward Wade Jr.

11. BIRTHPLACE OF FATHER (State or Country) Ark

12. MAIDEN NAME OF MOTHER Elsie McClearen

13. BIRTHPLACE OF MOTHER (State or Country) Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. E. Van Horen

(Address) Mesa, Idaho

15. Filed 1-7-31 191.....

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH RECEIVED JAN 12 1931

Dec (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...., that I last saw him after death alive on 12-11 1930, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Head injury sustained in automobile wreck (Skull fracture)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. P. Higgs M. D.

12-13 1930 (Address) Council Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Council Idaho

DATE OF BURIAL: 12/17 1931

20. UNDERTAKER: J. A. Huddleson

ADDRESS: Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SDRS. 24654

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73327

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 34
Primary Registration District No. 3020
Local Registrar's No. 21
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME William H. Alges.

(a) Residence. No. Mt. Home, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Common Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS
10. NAME OF FATHER ✓
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant Mrs. Jennie Losey.
(Address) Mt Home Idaho.

15. Filed Dec 30, 1930 A. Andrews Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) – 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation of Heart.
(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) Pneumonia at County Hospital - 3 weeks.
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G. S. Zacher M.D.
12-29, 1930 (Address) Mt Home Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt. Home Idaho.	12-27 1930
20. Undertaker	Address
G. S. Zacher.	Mt. Home Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73325

PLACE OF DEATH
County of Elmore.
City of Atlanta.

Registration District No. 34
Primary Registration District No. 2020 Local Registrar's No. 20
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

REGISTERED JAN 12 1931

2. **FULL NAME** Frank. L. Erickson.

(a) Residence. No. Atlanta Idaho. St.
(Usual place of abode.)
Length of residence in city or town where death occured. 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) June. 18.1876.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56	6	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Watchman, Atlanta Mines
(b) General nature of industry, business, or establishment in which employed (or employer) Company.
(c) Name of employer

9. BIRTHPLACE (city or town) Marquette.
(State or country) Michigan.

PARENTS

10. NAME OF FATHER Peter, E. Erickson.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Sweden/

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Unknown.

14. Informant E.W. Johnson.
(Address) % Elks Club. Boise, Idaho.

15. Filed Dec 30, 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 25 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood pressure
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) G.S. Zacher Coroner M.D.
12-30, 1930 (Address) Mt Home Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise, Idaho.	Dec. 30. 30.
20. Undertaker	Address
Summers & Krebs.	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7329

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 37
Primary Registration District No. 2020
(No. 749)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 19

RECEIVED JAN 12 1931

2. FULL NAME Bertha Maria Schram Kunnecke

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred 42 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of August Kunnecke

6. DATE OF BIRTH (month, day and year) 4-29-1870

7. AGE	Years	Months	Days	If LESS than 1 day,
	60	7	21	... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10. NAME OF FATHER — Schram
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant August Kunnecke
(Address) Mt. Home Ida.

15. Filed Dec 30, 1930 — Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12- 20 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12—16—, 1930, to 12-20—, 1930
that I last saw her alive on 12-20—, 1930
and that death occurred, on the date stated above, at 8 m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) F. E. Edmunds, M. D.
12-26-, 1930 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Mt. Home Ida.	12/23 1930

20. Undertaker G. G. Parker — Address Mt. Home Ida

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73330

PLACE OF DEATH
County of Elmore
City of Mt. Home

Registration District No. 34
Primary Registration District No. 2020
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 18

RECEIVED JAN 12 1931

2. FULL NAME Emery O. Cotton
(a) Residence. No. Mt Home Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single.
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) 3/25/71
7. AGE Years 59 Months 8 Days 16 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) ✓
12. MAIDEN NAME OF MOTHER ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) ✓

14. Informant G. S. Zacher
(Address) Mt Home Ida.
15. Filed Dec 13, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) — 11 (Day) — 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on 12-10-, 1930
and that death occurred, on the date stated above, at about 7:30 A. m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (duration) ..... yrs. ..... mos. 1 ds.
CONTRIBUTORY (Secondary) High Blood Pressure
..... (duration) 5 yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [signature], M. D.
12-13-, 1930 (Address) Mtn. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of ~~Burial, Cremation,~~ or Removal Delavan Minn. Date of Burial 12-13 1930
20. Undertaker G. S. Zacher. Address Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7332

PLACE OF DEATH
County of Fremont
City of Ashton

Registration District No. 10
Primary Registration District No. 6
(No.) Local Registrar's No. 3
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Viola Victoria Geyer

(a) Residence. No. St. Ashton, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: —
6. DATE OF BIRTH (month, day and year): May 18 - 1880
7. AGE: Years 50 | Months 6 | Days 11 | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home -
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: —
9. BIRTHPLACE (city or town) (State or country): Edison Ohio.

PARENTS
10. NAME OF FATHER: Geo. W. Geyer.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Edison Ohio.
12. MAIDEN NAME OF MOTHER: Ellen Lillian Geyer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Edison Ohio

14. Informant: Mrs. C. E. Geyer
(Address): Ashton Idaho.

15. Filed 11-29, 1930 A. Merchant Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 29- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15, 1930, to 11-29, 1930 that I last saw h[illegible] alive on 11-27, 1930 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:
(a) T.B. Pulmonary Tuberculosis
(duration) 7 yrs. 0 mos. 0 ds.
CONTRIBUTORY (Secondary) —
(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? Edison Ohio.
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) A. Merchant, M. D.
11-29, 1930 (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mt Anthony Idaho.	11-30 1930

20. Undertaker: Wm Hansen — Address: Mt Anthony Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73332

PLACE OF DEATH
County of Nez Perce
City of Peck

Registration District No. 93
Primary Registration District No. 2371
Local Registrar's No. 3
(No. 164)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME George Allingham

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jane Allingham

6. DATE OF BIRTH (month, day and year) July 12 - 1851

7. AGE	Years	Months	Days	If LESS than 1 day,
	79	4	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmed, when able.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bally Shannon Ireland

PARENTS

10. NAME OF FATHER Richard Allingham
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) "

14. Informant Jane Allingham
(Address) Peck, Ida

15. Filed Nov 18, 1930 Dan Lyle Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...
that I last saw h... alive on ....., 19...
and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Geo Allingham had been feeble minded and almost totally blind for a number of years - Helpless. No Doctor was Called. ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Dan Lyle, Registrar, M. D.
....., 19... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~	Date of Burial
Sunnyside Cemetery - Near Peck	11 - 20 1930
20. Undertaker: None	Address

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 6 1931

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Cambridge

Registration District No.

Primary Registration District No.

(No. 90 St.)

File No. 73333

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Evelyn Wells Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: No male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Mard (Write the word.)

6. DATE OF BIRTH. Oct (Month) 2 (Day) 1902 (Year)

7. AGE 28 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington Co Ida

10. NAME OF FATHER M H Wells

11. BIRTHPLACE OF FATHER (State or Country) Nevada

12. MAIDEN NAME OF MOTHER Lona O'Brien

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. H. Lingo

(Address) Grangeville, Idaho

15. Filed 1-4- 1931

DR. R. T. WHITEMAN
CAMBRIDGE, IDAHO
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21 1930, to Dec. 22 1930, that I last saw her alive on Dec 22 1930, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral Incompetency

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Polyomyelitis

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt D.C. M. D.

.....19..... (Address) Cambridge

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge

DATE OF BURIAL: Dec 24 1930

20. UNDERTAKER: J A Hudelson

ADDRESS: Cambridge Ida

SYMS - YORK CO., PTRS. & BDRS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7334

CERTIFICATE OF DEATH 86

PLACE OF DEATH
County of Washington
City of Weiser
Registration District No. .....
Primary Registration District No. 2117
Local Registrar's No. 29
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** John S Kirk

(a) Residence. No. Poor Farm St. 16
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wht	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb 28 - 1850

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
80	9	10	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) ..... (State or country) Oregon

PARENTS

10. NAME OF FATHER Dont Know
11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) Dont Know

14. Informant E. F. Hoffer
(Address) Weiser Rdd.

15. Filed Dec 16, 1930 W. R. Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 1, 1929, to Dec 8th, 1930
that I last saw him alive on Dec. 8th, 1930
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility.

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) L. L. Leonard, M. D.
12-9-30, 19..... (Address) Weiser Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	Dec 10 - 1930
20. Undertaker L. L. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 29 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73355

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
Local Registrar's No. 28
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Catherine Lynch 164
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE wht
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Patrick Lynch.

6. DATE OF BIRTH (month, day and year) Dec. 8-1847

7. AGE Years 82 Months 11 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis.

PARENTS
10. NAME OF FATHER Charles Galloway
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Mary Haney
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Agnes Lynch Weiser Idaho

15. Filed Dec 16, 1930 W. R. Hamilton M.H.M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 6th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1930, to Dec 6, 1930
that I last saw her alive on Dec 5, 1930
and that death occurred, on the date stated above, at 7:30 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? .....
(Signed) Fatchmitz, M. D.
12. 6. 1930 (Address) Weiser I.

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery
Date of Burial 12-9 1930

20. Undertaker L. C. Northam
Address Weiser Ida

RECEIVED DEC 29 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73330

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010 Local Registrar's No. 27
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Andrew L. Meyers

(a) Residence. No. Harrah St. Wash.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wht	married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Mattie Meyers

6. DATE OF BIRTH (month, day and year) Aug 13, 1864

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	3	19	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER William Meyers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.
12. MAIDEN NAME OF MOTHER Dont Know
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dont Know

14. Informant (Address) Clifford Meyers Harrah. Wash.

15. Filed Dec. 16, 1930 W. R. Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Heart attact, died before medical assistance arrived
.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? Coroner
(Signed) L. C. Northam, ~~M. D.~~
Dec 3, 1930 (Address) Weiser Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Yackima Wash.	12-5 1930
20. Undertaker L. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73337

PLACE OF DEATH
County of Valley
City of Cascade

Registration District No.
Primary Registration District No.
(No. 119
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Dean LeRoy Weller
(a) Residence. No. Cascade Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 17 - 1929

7. AGE Years 1 Months Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cascade Idaho

PARENTS
10. NAME OF FATHER E A Weller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Pe Ell Wash
12. MAIDEN NAME OF MOTHER Verde Emmerson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Vaudyck Idaho

14. Informant E A Weller
(Address)

15. Filed Dec 27, 1930 Mrs H P Gorton By M. Gardner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1930, to Dec 20, 1930
that I last saw him alive on Dec 17, 1930
and that death occurred, on the date stated above, at 9:00 P m.
The CAUSE OF DEATH* was as follows:
Intestinal influenza
(ellis - colitis)
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Cascade Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Roscoe C Ward, M. D.
12-20, 1930 (Address) Cascade Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cascade Idaho
Date of Burial: Dec 23 1930

20. Undertaker: A D Robb
Address: Cascade Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 12 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73338

PLACE OF DEATH
County of Valley
City of Arling

Registration District No. 15
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number)

Local Registrar's No.

2. FULL NAME Adrian C Carlson

(a) Residence. No. Arling St. 88
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: About 65 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stock raising.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Vermland Sweeden

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): ✓
12. MAIDEN NAME OF MOTHER: ✓
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Andrew Nelson
(Address)

15. Filed Dec 27, 1930 Kas H P Gerton By M. Gardner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1930, to Dec 24, 1930
that I last saw him alive on Dec 1st, 1930
and that death occurred, on the date stated above, at 5:00 P m.
The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary): Cardiac asthma
(duration) 5 yrs. 0 mos. 0 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Roscoe C Ward, M. D.
12/25, 1930 (Address) Cascade Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Cascade Ida
Date of Burial: Dec 26 1930

20. Undertaker: W. D. Robb
Address: Cascade

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED JAN 13 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73339

PLACE OF DEATH
County of Valley
City of McCall

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead instead of street and number.)

Local Registrar's No.

186

2. FULL NAME Jack Bunyan (State Insurance Fund) in charge.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS
10 NAME OF FATHER ✓
11 BIRTHPLACE OF FATHER (city or town) (State or country) ✓
12 MAIDEN NAME OF MOTHER ✓
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ✓

14 Informant: A. D. Robb
(Address)

15 Filed Dec 20, 1930 Mrs. H. P. Garton By M. Gardner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 19 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1930, to Dec 19, 1930, that I last saw him alive on Dec 19, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Fractured skull
Mental [illegible] Scattered
Accidental Explosion in Mine.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Deep burns & [illegible]
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? White Creek Mine
Did an operation precede death? yes Date of 12/[illegible]
Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Roy [illegible], M. D.
12/19, 1930 (Address) McCall Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Boise Idaho
Date of Burial: 19

20. Undertaker: A. D. Robb Cascade Ida
Address

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73340

PLACE OF DEATH
County of Twin Falls
City of Castleford

CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No. 101 b
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Robert Dean Snoderly

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 2 mos. 18 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Oct 11 — 1929

7. AGE: Years 1, Months 2, Days 18. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl — Ida.

PARENTS
10. NAME OF FATHER John Snoderly
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.
12. MAIDEN NAME OF MOTHER Luella Hansan
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) John Snoderly Castleford

15. Filed Dec. 30, 1930 J. H. Wurfler Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930, to Dec 29, 1930
that I last saw him alive on Dec 29, 1930
and that death occurred, on the date stated above, at 9 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. E. Shirts, M. D.
Dec 30, 1930 (Address) Buhl, Ida.

19. Place of Burial, Cremation, or Removal: Buhl Idaho — Date of Burial: 12/31 1930

20. Undertaker: L. Johnson — Address: Buhl, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7334

PLACE OF DEATH
County of Twin Falls
City of Buhl

Registration District No. 39
Primary Registration District No. 2087
Local Registrar's No. 101
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leonard Carroll Ferris

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. X yrs. 5 mos. 14 ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 1st - 1930

7. AGE Years X Months 5 Days 14 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buhl, Ida.

PARENTS
10. NAME OF FATHER Marlow F. Ferris
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas.
12. MAIDEN NAME OF MOTHER Margaret Carroll
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) Marlow F. Ferris Buhl Ida

15. Filed 12-16, 1930 J. H. Murphy Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14th, 1930, to Dec 15, 1930
that I last saw him alive on Dec 15, 1930
and that death occurred, on the date stated above, at 1.30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

(duration) yrs. mos. Two ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) R. E. Shurtz, M. D.
Dec 15, 1930 (Address) Buhl Ida

19. Place of Burial, Cremation, or Removal Buhl Ida Date of Burial Dec 16 1930

20. Undertaker L. J. Johnson Address Buhl Ida

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 5312

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Twin Falls
City of Burke.

Registration District No. 39
Primary Registration District No. 2087 Local Registrar's No.
(No. 90)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. **FULL NAME** Emily C. Galden

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 8 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 15 — 1849

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	11	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Xenia - Ill.

PARENTS

10. NAME OF FATHER Dickrey

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill

12. MAIDEN NAME OF MOTHER Margaret N. Brooks

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Xenia - Ill.

14. Informant Alice C. Hatchaker
(Address) Bayne Ida

15. Filed 12-8, 1930 J. F. Markley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
10-11, 1930, to 12-7, 1930
that I last saw her alive on 12-7, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.

(duration) ....yrs. ....mos. 1 ds.
CONTRIBUTORY (Secondary) Cardio-Vascular - Renal
(duration) ? yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? S. & clinical.
(Signed) Jno Jennings, M. D.
12-5, 1930 (Address) Burke Ida

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Burke - Ida	
20. Undertaker L. Johnson	Address Burke Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73343

PLACE OF DEATH
County of Twin Falls.
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 218
(No. 24 If death occurred in a hospital or institution, give its name instead of street and number.) Twin Falls Hospital

2. FULL NAME Raymond Bradley
(a) Residence. No. Kimberly St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 16 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
3	1	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER L H. Bradley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ark
12. MAIDEN NAME OF MOTHER Arizona Robertson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant L H Bradley
(Address) Kimberly

15. Filed 12/29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 16 1930 8 o'clock
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1930, to Dec 16 1930
that I last saw him alive on Dec 16 1930
and that death occurred, on the date stated above, at 8 5 m.
The CAUSE OF DEATH* was as follows:

Epidemic Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jos Davis, M. D.
Dec 16, 1930 (Address) Kimberly

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 19 1930
20. Undertaker	Address
F E Drake	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73344

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 217
(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James H. Knifong
(a) Residence. No. Browning, Missoiri. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 28th. 1910

7. AGE	Years	Months	Days	If LESS than 1 day,
	20		18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER James H. Knifonr Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Ovida Hubler
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Carlos Knifong
(Address) Eden, Idaho.

15. Filed 12/29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 16th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28th, 1930, to Dec 16th, 1930
that I last saw him alive on Dec 16th, 1930
and that death occurred, on the date stated above, at 7.50Pm
The CAUSE OF DEATH* was as follows:

Typhoid Fever
(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary) Brain Abscess
(duration) yrs. mos. 18 ds.

18. Where was disease contracted if not at place of death? Eden Idaho
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory Blood Cultures + Typhoid
(Signed) H E Lambert, M. D.
Dec 17 1930 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Browning Missouri. Date of Burial: Dec. 30 19

20. Undertaker: Grossman Mortuary Twin Falls, Ida. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73346

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 213

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.) Dr Wilson

2. FULL NAME Wm Beckley
(a) Residence. No. 3 1/4 N 1/2 West S Point I Falls St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 3/1859

7. AGE: Years 71 | Months 2 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10. NAME OF FATHER John Beckley
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Jane Davis
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Mrs Beckley
(Address) Twin Falls

15. Filed 12/27, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 PM
Dec 13 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Valvular
Insufficiency (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F E Drake Coroner M.D.
Dec 16, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Dec 17/30 19

20. Undertaker: F E Drake
Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JUN 14 10

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. [illegible]

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No. 214

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter L. Waite

(a) Residence. No. 219 Washington S. St. 90
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Birdie L. Waite

6. DATE OF BIRTH (month, day and year) Jan 1 - 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	11	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Cresco Iowa

PARENTS

10. NAME OF FATHER Nichols M. Waite

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Canada

12. MAIDEN NAME OF MOTHER Adelaide Dipon

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. Birdie L. Waite
(Address) 219 Washington St S.

15. Filed 12/27, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/7, 1930, to 12/10, 1930
that I last saw h[illegible] alive on 12/9, 1930
and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:
Oedema of the lungs and cardiac asthma

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac inefficiency and diabetes mellitus
Diabetes (duration) 20 yrs. mos. ds.

18. Where was disease contracted if not at place of death? Heart disease probably as long.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. D. Weaver M. D.
12/11, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or Removal	Date of Burial
Twin Falls	12-13 1930

20. Undertaker White Mortuary Inc. Address Twin Falls.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 1

DO NOT WRITE IN THIS SPACE
State File No. 73346

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 225

PLACE OF DEATH

County of Twin Falls
City of ~~Twin Falls~~ Kimberly
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

100a

2. FULL NAME Richard Carson Peterson

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 2, 1928

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Kimberly, (State or country) Idaho

PARENTS

10. NAME OF FATHER Carson Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway
12. MAIDEN NAME OF MOTHER Mable Maby
13. BIRTHPLACE OF MOTHER (city or town) Oakley, (State or Country) Idaho

14. Informant Carson Peterson,
(Address) Kimberly, Idaho

15. Filed 12/27, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec, (Month) 10, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1930, to Dec. 10, 1930
that I last saw him alive on Dec. 10, 1930
and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Respiratory infection
upper tract (duration) yrs. mos. 2 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? clinical
(Signed) J. M. Davis, M. D.
Dec. 10, 1930 (Address) Kimberly, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Oakley, Ida.	Dec. 12 1930
20. Undertaker	Address
D. E. Johnson	Burley,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73350

PLACE OF DEATH
County Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085

Local Registrar's No. 2 12

(No. 101 a If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lowdyr. Meyers

(a) Residence. No. [illegible] Polk St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 14 1930

7. AGE — Years | 4 Months | 26 Days | If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho

PARENTS

10. NAME OF FATHER: Lewis Meyers.
11. BIRTHPLACE OF FATHER (city or town) (State or Country): [illegible] N. D.
12. MAIDEN NAME OF MOTHER: Martha Klundt
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): N. D.

14. Informant: Helmuth Klundt
(Address) Twin Falls

15. Filed 12/27, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 10 (Month) 4.30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____
that I last saw h____ alive on ____, 19____
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? General
(Signed) F. E. Drake (Coroner), M. D.
Dec 11, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 12 1930
20. Undertaker: F. E. Drake	Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73551

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Gen. Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 211

2. FULL NAME Emmett Earl Eslinger

(a) Residence. No. Twin Falls Route #2 St. 117
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 10 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Oct 29-1914
7. AGE Years 16 Months 1 Days 7 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS
10. NAME OF FATHER J. O. Eslinger
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Edna Bland
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant J. O. Eslinger
(Address) Twin Falls Route #2

15. Filed Dec. 10th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1930, to Dec 6, 1930
that I last saw him alive on Dec 6, 1930
and that death occurred, on the date stated above, at 1.30 P m.
The CAUSE OF DEATH* was as follows:
Gangrenous appendicitis.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Dec. 3/30
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) H. W. Wilson M. D.
Dec 7, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Cemetery
Date of Burial: 12-8 1930
20. Undertaker: White Mortuary Inc
Address: Twin Falls. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73352

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 210

2. FULL NAME M S Hoover
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 4/1875

7. AGE: Years 55 | Months — | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Teacher
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Mrs M S Hoover
(Address) Twin Falls

15. Filed Dec. 10th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, to Dec 5, 1930
that I last saw him alive on Dec 5, 1930
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
acute pancreatitis
(duration) ..... yrs. ..... mos. 1 hour ds.
CONTRIBUTORY (Secondary) duodenal ulcer
(duration) ? yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Dec 5
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas. B. Scott, M. D.
Dec 8, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Dec 8 1930

20. Undertaker: F C Drok | Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14

DO NOT WRITE IN THIS SPACE
State File No. 73353

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1185
Local Registrar's No. 209

(No. 230--4Th Ave. East)
(If death occurred in a hospital or institution, give its name instead of street and number.)

75

2. FULL NAME Alford Disteli

(a) Residence. No. 230 - 4th Ave. East St. Twin Falls
(Usual place of abode)
Length of residence in city or town where death occurred. 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hannah Disteli

6. DATE OF BIRTH (month, day and year) Apr. 22Nd. 1865

7. AGE	Years	Months	Days	If LESS than 1 day,
	65	8	12	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn.

PARENTS

10. NAME OF FATHER Don+ Know

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

14. Informant A.R. Disteli
(Address) Calif. Appts. Twin Falls, Ida.

15. Filed Dec. 16th, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 4th. (Day) 30 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7, 1930, to Nov 27, 1930, that I last saw h-- alive on Nov 27 1930 and that death occurred, on the date stated above, at 12.45 AM m.

The CAUSE OF DEATH* was as follows:
Paralysis Agitans
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? ordinary

(Signed) H.W. Wilson, M. D.
Dec 4, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
IR Twin Falls Idaho	Dec. 6Th 1930
20. Undertaker	**Address**
Grossman Mortuary	Twin Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7335

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 2
(No. County Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Dr Wilson

2. FULL NAME Jeanie Beaton

(a) Residence. No. Filer St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: wife of John Beaton

6. DATE OF BIRTH (month, day and year): Jan 25/ 1862

7. AGE: Years 68 | Months 9 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10. NAME OF FATHER: John Steven
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: mary Grahes / Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Scotland

14. Informant: Miss Jeanie Beaton
(Address): Palalto Cali

15. Filed Dec. 1 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 3/30
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from May 30, 1930, to Dec 3, 1930
that I last saw h[illegible] alive on Dec 3, 1930
and that death occurred, on the date stated above, at 9:15 a m.
The CAUSE OF DEATH* was as follows:
Rheumatoid Arthritis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) H. Wilson, M. D.
Dec. 4, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Filer
Date of Burial: Dec 6 1930

20. Undertaker: F E Drake
Address: Twin Fal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73355

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085

Local Registrar's No. 247

(No. 101 9)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Betty Jana Lewis

(a) Residence. No. Twin Falls ranch St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 1./1928

7. AGE	Years	Months	Days	If LESS than 1 day,
	2	4	2	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER J L Lewis

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Laura Whittaker

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kansas

14. Informant Mrs J L Lewis

(Address) Twin Falls.

15. Filed Dec. 10th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec, 3/30 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? general

(Signed) F E Drake (Coroner) M. D.

Dec 6, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 6 1930

20. Undertaker	Address
F E Drake	Dec Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73356

PLACE OF DEATH

County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1885
Local Registrar's No. 206

(No. 1405--9th ave. East)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs. Kate Tibbals

(a) Residence. No. 1405--9Th Ave, East St.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. ~~5~~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 3Rd 1859

7. AGE	Years	Months	Days	If LESS than 1 day,
71	71	1	0	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10. NAME OF FATHER Richard R. Atwood
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N.Y.
12. MAIDEN NAME OF MOTHER Carline L. Tenny
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mich

14. Informant Roy Atwood
(Address) 1405--9th ave, East Twin Falls,

15. Filed Dec. 10th, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 3Rd. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12, 1926, to Dec 3, 1930
that I last saw h-- alive on Dec 3, 1930
and that death occurred, on the date stated above, at 1.10 P.M.
The CAUSE OF DEATH* was as follows:
Arterioclerosis
(duration) 20 yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Pulmonary Congestion
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Ordinary
(Signed) H.W. Wilson M. D.
Dec 4, 1930 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin alls, Ida	Dec 6 1930
20. Undertaker Grossman Mortuary	Address Twin Falls,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73357

PLACE OF DEATH

County of Twin Falls

City of Twin Falls,

Registration District No. 37

Primary Registration District No. 2085

Local Registrar's No. 205

(No. County General Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

44

2. FULL NAME Henry Jones

(a) Residence. No. Hollister Ida. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Willmoth Jones

6. DATE OF BIRTH (month, day and year): Sep 23Rd 1859

7. AGE: Years 71, Months 2, Days 7. If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Missouri.

PARENTS

10. NAME OF FATHER: Nathaniel Jones

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Davis

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Dont Know

14. Informant: Mrs. Henry Jones
(Address)

15. Filed Dec. 10th, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 1St (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16, 1930, to Dec 1, 1930
that I last saw him alive on Dec 1, 1930
and that death occurred, on the date stated above, at 1.35 m.
The CAUSE OF DEATH* was as follows:
Carcinoma stomach & intestines
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H W Wilson, M. D.
Dec. 4, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls
Date of Burial: Dec. 4Th 1930

20. Undertaker: Grossman Mortuary
Address:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JAN 1 4 1931

DO NOT WRITE IN THIS SPACE
State File No. 73358

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Hansen Ida. R #1)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Guy L. Cowan Sr.
(a) Residence. No. Hansen, Idaho, Route #1 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 23 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

31

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married,

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Grace Cowan

6. DATE OF BIRTH (month, day and year): Jan.22Nd1874

7. AGE 56 Years 11 Months 9 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ill

PARENTS

10. NAME OF FATHER: John Cowan
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Almeda Hill
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Pa.

14. Informant (Address): Mrs. Grace Cowan, Hansen, Idaho. Route #1

15. Filed January 3rd 1931. Elizabeth J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan —, 1910, to Dec 31, 1930
that I last saw h— alive on Dec. 31, 1930
and that death occurred, on the date stated above, at 5.PM.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.

..... (duration) 25 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Aortic Stenosis; Chronic adhesive pleuritis.
..... (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Ray
(Signed) H W Wilson, M. D.
Jan 3, 1931 (Address) Twin Falls Idaho

19. Place of Burial, Cremation, or Removal: Twin Falls, Idaho
Date of Burial: Jan3Rd. 1931

20. Undertaker: Grossman Mortuary Twin Falls, Ida
Address

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73359

PLACE OF DEATH

County of Twin Falls
City of Eden
Registration District No.
Primary Registration District No.
Local Registrar's No. 233
(No. 131) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Willie M. Brown

(a) Residence. No. Eden, St. Lane
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 11 1867

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	1	20	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10. NAME OF FATHER Jeard Brafford
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Corilla Tollman
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Granville Brown
(Address) Eden

15. Filed Jan 5th, 1931 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Jan 30~~ Dec. 31 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to Jan 30, 1931
that I last saw h alive on Dec 31st, 1930
and that death occurred, on the date stated above, at 12 M. m.
The CAUSE OF DEATH* was as follows:
Cardio vascular Renal Disease
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Paralysis. High Blood Pressure (duration) 10 yrs. mos. ds.
18. Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb, M. D.
Jan 31, 1931 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Jan 3 1931

20. Undertaker H. E. Drake Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

JAN 1 4 1931

DO NOT WRITE IN THIS SPACE
State File No. 73360

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No.
Primary Registration District No.
Local Registrar's No. 232

No. Dr Coughlin
(If death occurred in a hospital or institution, give its name instead of street and number.) Canby Hospital. 101 B

2. FULL NAME R. L. Colvard

(a) Residence. No. Kimberly St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 26/1904

7. AGE Years 26 Months 11 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Okla

PARENTS
10. NAME OF FATHER R L Colvard Sr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) N C
12. MAIDEN NAME OF MOTHER Maud Nolan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Texas

14. Informant R L Colvard Sr
(Address) In Kom Idaho

15. Filed January 14, 1931 Elizabeth J. S[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 30 — 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to Dec 30, 1930
that I last saw him alive on Dec 30, 1930
and that death occurred, on the date stated above, at 6 30 P m.
The CAUSE OF DEATH* was as follows: Pneumonia ~~Meningitis~~ Meningitis
(duration) yrs. mos. ✓ ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? At Home Twin Falls Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Laboratory finding
(Signed) H N Leite, M. D.
Dec 31, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Weiser
Date of Burial: Jan 2 1930

20. Undertaker: F E Drake
Address: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 14 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1311

PLACE OF DEATH
County of Twin Falls
City of Twin Falls
Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 230

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

101 A

2. FULL NAME Robert Grey

(a) Residence. No. Arrington Groups St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years: about 70 | Months: — | Days: — | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): Sheepheard
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14. Informant: Unknown
(Address) Twin Falls

15. Filed 12/29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Dec (Day) 27 (Year) 1930

17. I HEREBY CERTIFY, That I attended deceased from — , 19 , to — , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9.30 m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

— (duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? no
What test confirmed diagnosis? General

(Signed) F. E. Drake Coroner, M. D.
Dec 29, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls	Dec 30 1930
20. Undertaker	Address
F. E. Drake	Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE

State File No. .....

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 1085

Local Registrar's No. 237

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Dr Weaver 101a

2. FULL NAME Helen Lois Obershaw

(a) Residence. No. 355 6th Ave West St. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 9/1930

7. AGE Years — Months 1 Days 18 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Guy Obershaw

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Guy Obershaw

(Address) Twin Falls

15. Filed 12/29, 1930. Elizabeth J. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 27 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Dec 27, 1930, to ....., 19..

that I last saw her alive on Dec. 27, 1930

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

..... (duration) ..... yrs. ..... mos. ✓ ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C. D. Weaver, M. D.

12/29, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls — Date of Burial Dec 29 1930

20. Undertaker F. E. Drake — Address Twin Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 7336

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 239

(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1610

2. **FULL NAME** Estelle Steele

(a) Residence. No. Jerome Idaho. Route #2 St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of James B. Steele

6. DATE OF BIRTH (month, day and year) Jan. 7th 1882

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	17	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Ky.
(State or country)

PARENTS

10. NAME OF FATHER Sam Seaderberg

11. BIRTHPLACE OF FATHER (city or town) Ky.
(State or Country)

12. MAIDEN NAME OF MOTHER Ida Souther

13. BIRTHPLACE OF MOTHER (city or town) Ky
(State or County)

14. Informant James B. Steele
(Address) Jerome Ida. Route #2

15. Filed 12/29, 19 30 Elizabeth J. Smith Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 24th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1930, 19..., to Dec. 24, 1930, 19...
that I last saw her alive on Dec. 24, 1930, 19...
and that death occurred, on the date stated above, at 7PM. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar Right 3 lobes -
(duration) ... yrs. ... mos. 8 ds.
CONTRIBUTORY (Secondary) Hypertension - Arteriosclerosis Heart
(duration) 2 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Krug & Laboratory -

(Signed) Bureau A. H. Alexander M. D.
12/27/30, 19... (Address) Twin Falls, Idaho

19. Place of Burial, Cremation, or Removal: Twin Falls, Cemetary — Date of Burial: Dec. 27th 1930

20. Undertaker: Grossman Mortuary, Twin Falls? Ida. — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73084

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 226

PLACE OF DEATH

County of Twin Falls
City of Twin Falls
(No. None)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie E. Childers

(a) Residence. No. 1 Mile E on addison ave. St. 740
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of H. A. Childers.

6. DATE OF BIRTH (month, day and year) March 15 - 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	9	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Home work.
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Sirus Weller
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kentucky.
12. MAIDEN NAME OF MOTHER Brooks
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown.

14. Informant H. A. Childers.
(Address) Twin Falls Ida R.F.D.

15. Filed 12/29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 22 (Day) 1930 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Dec - 18 -, 1930, to Dec 22, 1930
that I last saw h~~er~~ alive on Dec 22 -, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) W N Leete, M. D.
12-24-, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls Ida.	19
20. Undertaker	Address
White Mortuary Inc	Twin Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73365

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
(No. Twin Falls County Hosp.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 228

2. FULL NAME Baby Wagner

(a) Residence. No. 0 St. 161 W
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years | Months | Days: 2 | If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: x
(b) General nature of industry, business, or establishment in which employed (or employer): x
(c) Name of employer: x

9. BIRTHPLACE (city or town) (State or country): Twin Falls Ida.

PARENTS

10. NAME OF FATHER: Clarence E. Wegnar
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Flora ~~Florence~~ Sanders
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Illinois

14. Informant: C. E. Wegner
(Address): Twin Falls Ida.

15. Filed 12/30, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17th, 1930, to Dec 20th, 1930
that I last saw her alive on Dec 14th, 1930
and that death occurred, on the date stated above, at 2 A m.
The CAUSE OF DEATH* was as follows:
Hemorrhage from bowels and mouth (Haemophelia)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Prematurity

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? In hospital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. E. Lamb, M. D.
Dec 28th, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation, or Removal~~: Twin Falls | Date of Burial: 12-20 1930

20. Undertaker: White Mortuary | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 1 4 1931

DO NOT WRITE IN THIS SPACE
State File No. 73366

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 224

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Arron Walborn County Hospital 101a

(a) Residence. No. ..... St. ..... alex
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec 14

7. AGE: Years 75 | Months 0 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Rancher
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Walburn
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unkn

14. Informant Geo. F. Huffman
(Address) Twin Falls

15. Filed 12/29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 20 (Month) (Day) 1930 (Year) 225

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1930, to Dec. 20, 1930
that I last saw him alive on Dec. 20, 1930, 19
and that death occurred, on the date stated above, at 2:30 A. m.
The CAUSE OF DEATH* was as follows: Pneumonia Lobar Right Acute
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Dilation Heart Chronic
(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? X ray Laboratory
(Signed) Duncan A Alexander M.D.
12/22/30, 19 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls | Date of Burial: Dec 23 1930

20. Undertaker: F E Drake | Address: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73367

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 223

(No. ..... County Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.) Dr Emes 117

2. FULL NAME Elsie Mildred Summers

(a) Residence. No. Kimberly St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day and year) Dec 28 1918

7. AGE Years 11 Months 11 Days 20 If LESS than 1 day, — hrs. or min.

8. OCCUPATION OF DECEASED —
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer —

9. BIRTHPLACE (city or town) (State or country) Okla

PARENTS
10. NAME OF FATHER F. J. Summers
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Elsa Robertson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Okla

14. Informant F. J. Summers
(Address) Kimberly

15. Filed 12/29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 20 1930 (Month) (Day) (Year) 11-55

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1930, to Dec 20, 1930
that I last saw her alive on Dec 20, 1930
and that death occurred, on the date stated above, at 11:55 a.m.
The CAUSE OF DEATH* was as follows:
General septicemia and surgical shock.
(duration) — yrs. — mos. 2 ds.
CONTRIBUTORY (Secondary) Ruptured append and appendectomy (duration) yrs. mos. 24 hrs.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Dec 20-30
Was there an autopsy? No.
What test confirmed diagnosis? Sup. ex observation
(Signed) Dr Emes, M. D.
12-20, 1930 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Twin Falls Date of Burial Dec 23 1930

20. Undertaker F. E. Drake Address Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73368

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 1085
(No. 286 Alexander St Twin Falls Ida.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 222

101a

2. FULL NAME Baby Whitaker
(a) Residence. No. 286 Alexander St Twin Falls, St. Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 27th 1930

7. AGE Years 2 Months 20 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls Ida.

PARENTS
10. NAME OF FATHER Henry Whitaker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ida
12. MAIDEN NAME OF MOTHER Blanch Lowe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Henry Whitaker
(Address) 286 Alexander St,

15. Filed 12/29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19, 1930, to Dec 20, 1930
that I last saw him alive on Dec 20, 1930
and that death occurred, on the date stated above, at 11.30A m.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia
(duration) ..... yrs. ..... mos. 7 ds.
CONTRIBUTORY (Secondary) none
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of ✓
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Clauchet M. D.
Dec 20, 1930 (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rigby Idaho. Date of Burial Dec. 22 1930

20. Undertaker Grossman Mortuary Address Twin Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL ~~STATISTICS~~

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73369

Registration District No. 37
Primary Registration District No. 2086
Local Registrar's No. 221

PLACE OF DEATH
County of Twin Falls
City of Filer

(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Fred J. Hawe

(a) Residence. No. ..... Filer on Ranch St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Dr Dwight 10.00

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 10/30

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Dr Joint
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER E J Hawe
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis
12. MAIDEN NAME OF MOTHER Fleet Rosy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Arkansas

14. Informant E J Hawe
(Address) Filer Idaho

15. Filed 12/29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 19 4-30
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17, 1930, to Dec. 19, 1930, that I last saw him alive on Dec. 19, 1930, and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No. Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical.

(Signed) F. A. Burgess, M. D.
Dec. 19, 1930 (Address) Filer Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls — Date of Burial: Dec 20 1930

20. Undertaker F C Drake — Address Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7337

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 227

(No. County General Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

151

2. FULL NAME Elsie Lee Milligan

(a) Residence. No. Filer Idaho. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo. Milligan

6. DATE OF BIRTH (month, day and year) Mar. 17th 1903

7. AGE	27 Years	8 Months	1 Days	If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri.

PARENTS

10. NAME OF FATHER Geo. Lee Ray

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Josephine Deckard

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri.

14. Informant Geo. Lee Ray,
(Address) Buhl Ida. P.O. Box 264

15. Filed 12/29, 1930. Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 18th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1930, to Dec. 18, 1930
that I last saw h[illegible] alive on Dec. 18, 1930
and that death occurred, on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:
Inflamatory tumor of mesentery & small bowel producing gangrene. Non-malignant.
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Paresis of bowel and auto-intoxication (duration) yrs. mos. 4 ds.

18. Where was disease contracted if not at place of death? No
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Laboratory.

(Signed) F. A. Dwight, M. D.
Dec. 20, 1930 (Address) Filer Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Filer Idaho.	Dec. 20 1930

20. Undertaker	Address
Grossman Mortuary	Twin Falls,

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73371

PLACE OF DEATH
County of Twin Falls
City of Twin Falls

Registration District No. 37
Primary Registration District No. 2085
Local Registrar's No. 219

(No. County Gen Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1000

2. FULL NAME Cardella Edwards

(a) Residence. No. Kimberly Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 16th 1930

7. AGE — Years | Months: 10 | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Okla.

PARENTS

10. NAME OF FATHER Linard C. Edwards
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri.
12. MAIDEN NAME OF MOTHER Clara Collins
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Linard C. Edwards,
(Address) Kimberly Ida.

15. Filed 12/29, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 17th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 12 -, 1930, to Dec 17, 1930
that I last saw her alive on Dec 17, 1930
and that death occurred, on the date stated above, at 9PM m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. M. Davis, M. D.
Dec 18, 1930 (Address) Kimberly Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho.	Dec. 19 1930

20. Undertaker: Grossman Mortuary Twin Falls, Ida. Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

FILED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 13372

PLACE OF DEATH
County of Twin Falls,
City of Twin Falls,

Registration District No. 37
Primary Registration District No. 1085
Local Registrar's No. 220

(No. 345-5th, West)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stella Klundt

(a) Residence. No. 345--5th. Ave, West St. Twin Falls, 101a
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov.17th-1930

7. AGE	Years	Months	Days	If LESS than 1 day,
		1		hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Twin Falls, Idaho.

PARENTS

10. NAME OF FATHER Geo. Klundt

11. BIRTHPLACE OF FATHER (city or town) (State or Country) No. Dak.

12. MAIDEN NAME OF MOTHER Ethel Ross

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Geo. Klundt.
(Address) 345--5th. ave. West Twin Falls,

15. Filed 12/29, 1930 Elizabeth J. Smith Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 17th 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Unatended, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 3.15AM
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Home, 345 5Th west
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? General
(Signed) H. R. Drake Coroner
Dec, 18, 1930 (Address) Twin Falls

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Twin Falls, Idaho.	Dec.19-1930

20. Undertaker Grossman Mortuary Address Twin Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73373

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 51

PLACE OF DEATH
County of Benewah
City of St. Maries
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Alvin Earl Kiehle 1610

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	white	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		15	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER Herman Kiehle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wis
12. MAIDEN NAME OF MOTHER Clara Woods
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ida

14. Informant Herman Kiehle
(Address) St. Maries, Ida

15. Filed Jan 12, 1931 Walter Broberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-14, 1930, to 12-29, 1930
that I last saw him alive on 12-25, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Premature
7 mo
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) L. L. Espe, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Maries	12-30 1930
20. Undertaker Lee E. Mitchell	Address St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 14

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73374

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 50

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lydia E. Martin 137

(a) Residence. No. St Maries St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Percy Martin

6. DATE OF BIRTH (month, day and year)

7. AGE Years Months Days — Unknown — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Bromer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No
12. MAIDEN NAME OF MOTHER No
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) No

14. Informant Lydia Martin
(Address) St Maries

15. Filed Jan 12, 1931 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-15, 1930, to 12-18, 1930
that I last saw her alive on 12-18, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Ovarian cyst
Uterine Cancer
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G G Estes, M. D.
....., 19.... (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Woodlawn Cem — Date of Burial: Dec 21 1930

20. Undertaker: Geo E Mitchell — Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73375

PLACE OF DEATH
County of Benewah
City of

Registration District No. 32
Primary Registration District No. 2049
(No. St. Maries Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 49

44

2. FULL NAME James Gunderson
(a) Residence. No. Santa Ida St. Santa, Ida
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 61 | Months 1 | Days | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Norway

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: C A Walker
(Address) Santa Ida

15. Filed Jan 7th, 1931 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4, 1930, to Dec 17, 1930
that I last saw him alive on Dec 4, 1930
and that death occurred, on the date stated above, at ... m.
The CAUSE OF DEATH* was as follows:
Carcinoma of the Stomach
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) C A Robins M. D.
1/6, 1931 (Address) St Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: Dec 19 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73376

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Esfe Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 48

89

2. FULL NAME Daniel S ~~Lutz~~ Lutz

(a) Residence. No. ..... St. Coeur d'Alene
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Tyna Lutz

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
70	1	26	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Harmony, Penna.
(State or country)

PARENTS

10. NAME OF FATHER Daniel Lutz
11. BIRTHPLACE OF FATHER (city or town)
(State or Country)
12. MAIDEN NAME OF MOTHER Christina Moyer
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country)

14. Informant Doris Cleveland
(Address) St Maries

15. Filed Jan 1st, 1931 Walter Broberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-5, 1930, to 12-15, 1930
that I last saw him alive on 12-15, 1930
and that death occurred, on the date stated above, at 12:30 P m.
The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) G G Esfe, M. D.
12-15, 1930 (Address) St. Maries, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Coeur d'Alene
Date of Burial 19

20. Undertaker Geo E Mitchell
Address St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73377

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 47

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

1889

2. FULL NAME Samuel E. Kirking

(a) Residence. No. St Maries St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov 23 - 1878

7. AGE Years 52 Months Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Natchitaches
(State or country) Tous

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) .....
(State or Country)

14. Informant Frank Chamberlin
(Address) St Maries

15. Filed Jan 12, 19.... Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Struck by train
(accidental)
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. G. Eisfe, Coroner, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries
Date of Burial: Dec 18 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73373

PLACE OF DEATH
County of Benewah
City of St Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Eppes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 26

206

2. FULL NAME Eloise Baby Warner

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) St Maries Ida
(State or country)

PARENTS

10. NAME OF FATHER P H Warner

11. BIRTHPLACE OF FATHER (city or town) Plevna
(State or Country) Mont

12. MAIDEN NAME OF MOTHER Jennie Hyde

13. BIRTHPLACE OF MOTHER (city or town) Delaware
(State or Country) Colo

14. Informant P H Warner
(Address) St Maries Ida

15. Filed Jan 12, 1931 Walter Boberg
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
12-13, 1930, to 12-13, 1930
that I last saw her alive on 12-13, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Too long delayed in birth canal

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G L Eppes, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Maries	Dec 14 1930
20. Undertaker	**Address**
Grace Mitchell	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN 14 1931

DO NOT WRITE IN THIS SPACE
State File No. 73379

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
Local Registrar's No. 45

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

749

2. FULL NAME Fredrick Harroun

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Harroun

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 74 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) .....

PARENTS

10. NAME OF FATHER: Amel Harroun
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Wis
12. MAIDEN NAME OF MOTHER: Sarah Dancy
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mich

14. Informant: Bryan Harroun
(Address) St Maries Idaho

15. Filed Jan. 12, 1931 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-11, 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred, on the date stated above, at 6 a m.
The CAUSE OF DEATH* was as follows:
Apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Multiple fibroma
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G. Glasfe Coroner, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries | Date of Burial: Dec 13 1930

20. Undertaker: Geo E Mitchell | Address: St Maries

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 14 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73380

PLACE OF DEATH
County of Benewah
City of St. Maries

Registration District No. 32
Primary Registration District No. 2049
(No. Espes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 44

126

2. FULL NAME Mrs Edith Irene Hughes
(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 26 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Ernest V Hughes

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 34, Months 11, Days 23. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Park Rapids Minn

PARENTS
10. NAME OF FATHER: Alonzo Somers
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Green Lake Minn
12. MAIDEN NAME OF MOTHER: Florence Marshall
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Pennston Minn

14. Informant: Mrs Florence E Feit
(Address) St Maries Idaho

15. Filed Jan 12, 1930 Walter Boberg Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-5, 1930, to 12-11, 1930
that I last saw her alive on 12-11, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows: General peritonitis
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Miscarriage
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) G G Espe, M. D.
....., 19..... (Address) .....

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: St Maries Ida
Date of Burial: Dec 14 1930

20. Undertaker: Geo E Mitchell
Address: St Maries

...should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ...TION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED JAN 14 1931

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of St. Maries, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32

Primary Registration District No. 2049

(No. ..... Second St.)

File No. 73381

Registered No. 43

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edgar Allen Coleman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. Feb (Month) 6 (Day) 1869 (Year)

7. AGE 41 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Prospecting and Mining

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wetmore Col

10. NAME OF FATHER J W Coleman

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Elizabeth Rough

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm DeBrey

(Address) St Maries

15. Filed Dec 10 1930 Walter Boberg Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 3rd (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 19 1930, to Dec 3rd 1930, that I last saw him alive on Dec 1st 1930, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows: Coronary occlusion

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) ——

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Robins M. D.

12/3 1930 (Address) St Maries, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Butte, Mont.

Former or usual residence " "

19. PLACE OF BURIAL OR REMOVAL St Maries

DATE OF BURIAL Dec 5 1930

20. UNDERTAKER Geo E Mitchell

ADDRESS St Maries

SYMS - YORK CO., PTRS. & SDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

REC'D DEC 4 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73383

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 112

PLACE OF DEATH
County of Shoshone
City of Wallace
(No. 422 Bank St)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Henry Howes

(a) Residence. No. 422 Bank St. St. at Wallace
(Usual place of abode)
Length of residence in city or town where death occurred 44 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or ~~WIFE~~ of): Elizabeth Craig Howes dec.

6. DATE OF BIRTH (month, day and year): Oct 18 1848

7. AGE: Years 82 | Months 1 | Days 3 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): England

PARENTS

10. NAME OF FATHER: William Howes
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Elizabeth West
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England

14. Informant: Miss Musa Howes
(Address): Wallace Idaho

15. Filed Dec 4, 1930 F. L. Craig Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 21st 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6th, 1930, to Nov 21st, 1930
that I last saw him alive on Nov 21st, 1930
and that death occurred, on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): no apoplexy or cancer

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) E S Storm, M. D.
Nov 24th, 1930 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace Idaho — Date of Burial: 11/24 1930

20. Undertaker: Bruce G. Mortell — Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73384

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 111

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry R. Craddick 1880

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Craddick

6. DATE OF BIRTH (month, day and year): Sept 8 1899

7. AGE: Years 31, Months 2, Days 10. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mill Man
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: Bunker Hill Co

9. BIRTHPLACE (city or town) (State or country): Cameron Ida

PARENTS
10. NAME OF FATHER: William F. Craddick
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canello Wash
12. MAIDEN NAME OF MOTHER: Esther Greenwood
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Missouri

14. Informant: William F. Craddick
(Address)

15. Filed Nov 20, 1930. F. L. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930 to Nov 18, 1930
that I last saw him alive on Nov 17, 1930
and that death occurred, on the date stated above, at 12:20 a m.
The CAUSE OF DEATH* was as follows:
Septicaemia
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary): Crushed leg amputation Auto accident Instant
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of Nov 11
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Dr. Mowary, M. D.
11/19, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida — Date of Burial: Nov 20 1930

20. Undertaker: R. L. Stout — Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73385

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1001
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 110

161a

2. FULL NAME Luella May Ohman
(a) Residence. No. 201 - 5th St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 29 - 1930

7. AGE Years | Months | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Wallace
(State or country) Idaho

PARENTS
10. NAME OF FATHER Otto Ohman
11. BIRTHPLACE OF FATHER (city or town) Rossland
(State or Country) B. C.
12. MAIDEN NAME OF MOTHER Lena Ohman
13. BIRTHPLACE OF MOTHER (city or town) Butte
(State or County) Mont.

14. Informant (Address) Mrs Ohman 501 - 5th Wallace, Ida

15. Filed Nov 17, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Nov 17, 1930
that I last saw her alive on Nov 17, 1930
and that death occurred, on the date stated above, at 1 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Guardian

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature birth 7½ mo.

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) F. L. Quigley, M. D.
11/17/30, 19 (Address)

19. Place of Burial, Cremation, or Removal Wallace, Idaho | Date of Burial Nov 19 1930

20. Undertaker J. A. Bever Ward and Co. | Address Wallace, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73386

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 109

47

2. FULL NAME Clara Bishop
(a) Residence. No. Mullan, Idaho St. Mullan, Ida
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Louis A Bishop

6. DATE OF BIRTH (month, day and year) May 24-1882

7. AGE Years 48 Months 6 Days 13 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS
10. NAME OF FATHER Kempf.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) L. A Bishop Mullan, Idaho.

15. Filed Nov 14, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Nov 12, 1930
that I last saw her alive on Nov 7, 1930
and that death occurred, on the date stated above, at 11:30 A.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Carcinoma of Breast with General Metastases

(duration) 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Nov 21-1929
Was there an autopsy? No
What test confirmed diagnosis? Path Ex of Tumor
(Signed) Max T. Smith, M. D.
11/13/30, 19..... (Address) Wallace Ida

19. Place of Burial, Cremation, or Removal Mullan, Idaho
Date of Burial Nov. 14 1930

20. Undertaker J. A. Bever Ward Und. Co.
Address Wallace, Idaho

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73387

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 108
(No. 31 Cottonwood Ave, Wallace, Id,
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary A. Cantrell
(a) Residence. No. 31 Cottonwood Ave St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. 2 yrs. ~~10~~ 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

88B

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of T. M. Cantrell

6. DATE OF BIRTH (month, day and year) April 2nd 1860

7. AGE: 70 Years | Months: ~~10~~ 7 | Days: 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Springfield Missouri

PARENTS
10. NAME OF FATHER: Wm A. Carr
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known Virginia
12. MAIDEN NAME OF MOTHER: Catherine Wooley
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Not Known Virginia

14. Informant: Anna C. Lucas
(Address) 31 Cottonwood, Wallace Idaho

15. Filed Nov 13, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to Nov 12, 1930
that I last saw her alive on Nov 11, 1930
and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows: Myocarditis Chr
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary): Arteriosclerosis
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) D. S. Mowery, M. D.
11/12, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Harrington, Wash. | Date of Burial: Nov. 13 1930.

20. Undertaker: B. G. Worstell, | Address: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13388

RECEIVED DEC 24 1930

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. 422 Bank St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 107

2. FULL NAME Elizabeth Krieg Howard

(a) Residence. No. 422 Bank St. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

88 V

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry E. Howard,

6. DATE OF BIRTH (month, day and year) June 21 1848

7. AGE: Years 82 | Months 4 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Neillsville Wisconsin

PARENTS

10. NAME OF FATHER Geo. W. Krieg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) England
12. MAIDEN NAME OF MOTHER Maria Havers
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) New York

14. Informant Mrs. A. J. Dunn
(Address) Wallace Idaho

15. Filed Dec 12, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 10 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6, 1930, to Nov. 10, 1930
that I last saw her alive on Nov 10, 1930
and that death occurred, on the date stated above, at 10.30 A.m.
The CAUSE OF DEATH* was as follows:
Myocardial degeneration
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pleurisy
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Fred V. Griffith M.D.
Nov 12, 1930 (Address) Wallace

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	Nov. 12 1930
20. Undertaker B. G. Worstell	Address Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 75389

PLACE OF DEATH
County of Shoshone
City of Gem

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 106
(No. Residence) 162
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lorraine Walter
(a) Residence. No. Gem, Idaho St. Gem Idaho
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 27 - 30

7. AGE Years Months 3 Days 11 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS
10. NAME OF FATHER Everett Walter
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tacoma Wash
12. MAIDEN NAME OF MOTHER Violet Monroe
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant (Address) Everett Walter Gem Idaho.

15. Filed Nov 10, 1930 F. R. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1930, to 11/8, 1930
that I last saw her alive on Nov 7, 1930
and that death occurred, on the date stated above, at 12 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Marasmus

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) (premature twin)

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Bean, M. D.
....., 19.... (Address)

19. Place of Burial, Cremation, or Removal Wallace Idaho. Date of Burial Nov 10 19..

20. Undertaker J. A. Bever Ward Und Co. Address Wallace Idaho

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7339

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
Local Registrar's No. 105
11 N 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Chris Anderson

(a) Residence. No. Kellogg, Ida St. Kellogg, Idaho.
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Leasing - Self.

9. BIRTHPLACE (city or town) (State or country) Norway.

PARENTS

10. NAME OF FATHER Anders Anderson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Norway.

12. MAIDEN NAME OF MOTHER Lovaas

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Norway.

14. Informant Peter Sjursen (Address) Wardner, Idaho.

15. Filed Nov 9, 1930 F. K. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1930, to, 19....
that I last saw him alive on Nov 4th, 1930
and that death occurred, on the date stated above, at 7 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. C. Lindsay, M. D.
11/4, 1930 (Address) Kellogg Idaho.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho.	Nov 9 1930
20. Undertaker J. A. Bence Ward Und. Co.	Address Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73391

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 104
(No. Providence Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Frank William Eschbach 100a
(a) Residence. No. Mace Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) July 15 1913
7. AGE Years 17 Months 3 Days 16 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Ore Sorter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hecla Mining Co
9. BIRTHPLACE (city or town) (State or country) Mace, Idaho.

PARENTS
10. NAME OF FATHER Phillip Eschbach
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mayance Germany
12. MAIDEN NAME OF MOTHER Emma Maymaster
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Minnesota

14. Informant Phillip Eschbach
(Address) Mace, Idaho

15. Filed Nov 4, 1930. F. L. Tingley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 1 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 31, 1930 to Nov 1, 1930
that I last saw him alive on Nov 1, 1930
and that death occurred, on the date stated above, at 4 a m.
The CAUSE OF DEATH* was as follows:
Pneumonia Bronchial
(duration) yrs. 3 mos. 4 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. 4 mos. 5 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) D. H. Howard M. D.
11/3, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Wallace, Idaho Date of Burial Nov 4 1930
20. Undertaker B. G. Worstell Address Wallace

RECEIVED DEC 24 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7339

PLACE OF DEATH
County of Shoshone
City of Mullan

Registration District No. 70
Primary Registration District No. 1011
(No.) 196
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 103

2. FULL NAME August Kaipi

(a) Residence. No. / Mullan, Idaho St. Mullan, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Kaipi.

6. DATE OF BIRTH (month, day and year) Oct 13 - 1892.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	0	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Morning Mng. Co.

9. BIRTHPLACE (city or town) (State or country) Finland

PARENTS
10. NAME OF FATHER Thomas Kaipi.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland.
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland.

14. Informant Rosa Kaipi.
(Address)

15. Filed NOV 5, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 1 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw him alive on , 19
and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows: Accidentally Electrocuted in Morning Mine
(duration) yrs. mos. Instant ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) R. Norbert Coroner
11/ , 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mullan, Idaho.	Nov 5 1930
20. Undertaker J. A. Bowers Ward and Co.	Address Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73393

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 66

(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Ellen Syphert

(a) Residence. No. St.
(If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): Widow

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of: Wm. Syphert

6. DATE OF BIRTH (month, day and year): May 10, 1841

7. AGE: 89 Years | Months | Days | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Missouri

PARENTS

10. NAME OF FATHER: Thomas Stanly
No inf.

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): No inf.

14. Informant: Mrs. Ed. Hearing
(Address): Kellogg, Idaho.

15. Filed Dec. 28, 1930 Mrs. Helen M. Beale Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1930 to , 19
that I last saw h alive on Dec 18, 1930.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Apoplexy.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) W. C. Lindsay, M. D.
Dec. 19, 1930 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane, Wash — Date of Burial: 12/22/30 19

20. Undertaker: M. C. Thornhill — Address: Kellogg, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73395

PLACE OF DEATH

County of Power

City of American Falls, Idaho

Registration District No. 23

Primary Registration District No. 2072

Local Registrar's No. 28

(No. Bethony Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

885

2. FULL NAME Irene Daniels

(a) Residence. No. Arbon Valley St.
(Usual place of abode)
Length of residence in city or town where death occurred. 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of T.C.Daniels

6. DATE OF BIRTH (month, day and year) Sept 3rd 1902

7. AGE	Years	Months	Days	If LESS than 1 day,
	28	2	25	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS

10. NAME OF FATHER Leon Condit

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Marry Rice

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant T C Daniels
(Address) Arbon, Idaho

15. Filed 1/1, 1931 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 28th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930 to Dec 28, 1930
that I last saw her alive on Dec 28, 1930
and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C F. Schiek, M. D.

12/29/30, 19 (Address) Am Falls, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal		Date of Burial
Rupert	Idaho	19

20. Undertaker A W Davis Am

Address Falls, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73396

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 42
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Minnie S. Cole
(a) Residence. No. 227 S. Seventh St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widowed
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua S. Cole
6. DATE OF BIRTH (month, day and year) June 12-1854
7. AGE Years 76 Months 4 Days 29 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Penn
PARENTS
10. NAME OF FATHER James Roberts
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER Charity A Mastellar
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown
14. Informant (Address) B G Forbes Payette Idaho
15. Filed Nov 15 1930 J. B. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 12 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to Nov. 12, 1930
that I last saw her alive on November 12, 1930
and that death occurred, on the date stated above, at 5:30 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cancer of gallbladder
(duration) Unknown yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Palpable tumor
(Signed) O. H. Avery, M. D.
10-14-, 1930 (Address) Payette Ida
19. Place of Burial, Cremation, or Removal Payette Idaho Date of Burial Nov 14 1930
20. Undertaker Glenn C. Landon Address Payette Ida

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7339

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1018
Local Registrar's No. 41
(No.) 6 Va
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Bough Lightfoot
(a) Residence. No. 430 - N. 7th St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Hal C. Lightfoot.

6. DATE OF BIRTH (month, day and year) Dec. 2. 1894

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	—	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10. NAME OF FATHER Elmer Nichols

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Alice Bough

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant Hal C. Lightfoot
(Address) Payette Idaho

15. Filed Nov 2 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10, 1930, to Oct 31, 1930
that I last saw h~~e~~r alive on Oct 31, 1930
and that death occurred, on the date stated above, at 10P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Aleno-myelogenous leukemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? W. J. Welch Laboratory
(Signed) M. D.
Nov. 1, 1930 (Address) Queens Ore.

19. Place of Burial, Cremation, or Removal	Date of Burial
Mountain Home	Nov 3 1930
20. Undertaker	Address
Glenn C. Sanders	Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

REGISTERED DEC 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 13308

Local Registrar's No. 40

1. PLACE OF DEATH

County of Payette

City of Emmettland

Registration District No. 4

Primary Registration District No. 1008.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. 70

2. FULL NAME Georgia M. Fretwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 29 (Day) 1911 (Year)

7. AGE: 18 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Vale, Ore.

10. NAME OF Father: E. E. Fretwell

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Josephine Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. E. Fretwell

(Address) Emmettland, Ida.

15. Filed Oct 31/1930 19 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1930. to Oct 28 1930., that I last saw her alive on Oct 28 1930., and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Polio-encephalitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

10/31/1930 (Signed) W. P. Weeks M. D.

(Address) Ontario, Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Same

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ontario, Ore. DATE OF BURIAL: Oct 30 1930

20. UNDERTAKER: A. L. Peterson ADDRESS: Ontario Ore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19. RECEIVED DEC 16 1930

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ..... St.)

State File No. 73399

Local Registrar's No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Lester Seward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Jan. (Month) 1 (Day) 1859 (Year)

7. AGE: 71 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF Father: Thomas M. Seward

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: N. H. Springher

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J B Fane
(Address) Ontario Ore

15. Filed Oct 27/1930 19 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1930, to Oct 25 1930, that I last saw him alive on Oct 25, 1930, and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Chronic intero nephritis
Chronic myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

11/22 1930 (Signed) N. J. Weese M. D.
(Address) Ontario Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ontario Ore

DATE OF BURIAL: Oct 27 1930

20. UNDERTAKER: A L Peterson

ADDRESS: Ontario

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED DEC 18 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73400

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 38
(No.) 22
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lavez. Preston.
(a) Residence. No. 107 - 7th St. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ none
6. DATE OF BIRTH (month, day and year) Oct-18-19
7. AGE Years 9 Months — Days 5 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work school girl.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS
10. NAME OF FATHER Herbert T. Preston.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.
12. MAIDEN NAME OF MOTHER Elizabeth Benson.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Informant (Address) Herbert T. Preston Payette Ida.
15. File Oct 25/1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 23 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1930, to Oct 23, 1930
that I last saw her alive on Oct 23, 1930
and that death occurred, on the date stated above, at 10 a. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Anterior poliomyelitis (bulbar type)
(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Fox M. D.
Oct 24, 1930 (Address) Payette Ida.

19. Place of Burial, Cremation, or Removal Weiser Ida. Date of Burial Oct-24 1930
20. Undertaker Glenn C Loudon Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73401

PLACE OF DEATH
County of Payette
City of Payette.

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 37
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Noah Webster Lewis
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) widower.

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Martha E. Lewis.

6. DATE OF BIRTH (month, day and year) Sept 18-1842

7. AGE Years 88 Months 1 Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn.

PARENTS
10. NAME OF FATHER John Lewis.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Adaline Webster
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown.

14. Informant (Address) Harry T. Lewis

15. Filed Oct 22, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH 131

16. DATE OF DEATH Oct (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1929, to Oct 20, 1930
that I last saw him alive on Oct 20, 1930
and that death occurred, on the date stated above, at 11 30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cardiovascular renal disease

indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? No
What test confirmed diagnosis? none
(Signed) Merrill R. [illegible] M. D.
Oct 22, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal New Plymouth
Date of Burial Oct 22 1930

20. Undertaker Glenn C. Sanders
Address Payette. Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73402

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 36
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elza Heath
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Alice Heath
6. DATE OF BIRTH (month, day and year) Mar 2
7. AGE Years 62 Months Days If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) + Carpenter
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ohio
PARENTS
10. NAME OF FATHER John Heath
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Alexander
13. BIRTHPLACE OF MOTHER (city or town) (State or County) ✓ ✓
14. Informant (Address) Julia Heath Payette Ida
15. Filed Oct 23 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH Oct (Month) 20 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 20, 1930, to Oct 20, 1930
that I last saw him alive on Oct 20, 1930
and that death occurred, on the date stated above, at 1 a. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(duration) ..... yrs. ..... mos. 6 ds.
CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J. C. Woodward M. D.
Oct 22 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal Payette Ida
Date of Burial Oct 22 1930
20. Undertaker J. H. Adair
Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73403

PLACE OF DEATH
County of Fayette
City of Fairfield

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 35
(No.) 74a
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carrie N. Manning
(a) Residence. No. Minneapolis Minn
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ F
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of F. H. Manning
6. DATE OF BIRTH (month, day and year) July 4
7. AGE Years 48 Months 3 Days 11 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Minn
PARENTS
10. NAME OF FATHER Jas H Layman
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Minn
12. MAIDEN NAME OF MOTHER Stella Parker
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Minn
14. Informant (Address) F. H. Manning Minneapolis Minn
15. Filed Oct 17/1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 14, 1930, to Oct 15, 1930
that I last saw her alive on Oct 14, 1930
and that death occurred, on the date stated above, at 3 a m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
apoplexy.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death? X
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) W. J. Neese M. D.
Oct, 16, 1930 (Address) Ontario, Ore
19. Place of Burial, Cremation, or Removal Minneapolis Minn
Date of ~~Burial~~ Removal Oct 16 1930
20. Undertaker J. H. Adair Peterson Furn Co Fayette Ida
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 1 6 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73404

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 34
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mr Fred S. Hoff 90
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: none
6. DATE OF BIRTH (month, day and year): unknown
7. AGE: Years 80 | Months | Days | If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country): unknown

PARENTS
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County): unknown

14. Informant (Address): R E Cook R.R. 2 Box 590 Portsville, Cal.
15. Filed Oct 19/1930 19 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1910, 19, to 1915, 19
that I last saw him alive on Oct 1, 1930
and that death occurred, on the date stated above, at m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) 5 yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J R Woodward M. D.
10/17, 1930 (Address) Payette, Ida.

19. Place of Burial, Cremation, or Removal: Payette Idaho. Date of Burial: Oct 18 1930
20. Undertaker: Glenn C. Landon Address: Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73465

PLACE OF DEATH
County of Payette
City of Payette.

Registration District No. 4
Primary Registration District No. 1008.
Local Registrar's No. 33

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Myrtle Alice Alspach. 47

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Geo. Alspach.

6. DATE OF BIRTH (month, day and year) Mar 2

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
46	7	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS

10. NAME OF FATHER A. L. Barr.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio.
12. MAIDEN NAME OF MOTHER Laura Plumb.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ohio.

14. Informant Nora Parsons
(Address) .....

15. Filed Oct 15 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 12, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 15, 1930, to October 12, 1930
that I last saw her alive on October 12, 1930
and that death occurred, on the date stated above, at 9:00 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of breast. Left breast amputated May 1926. Recurrence in chest. ill about 1½ years

(duration) 5- yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes Date of May 1926
Was there an autopsy? No
What test confirmed diagnosis? X-Ray

(Signed) O H Avey, M. D.
....., 19..... (Address) Payette Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Boise Idaho.	Oct 14 1930
20. Undertaker	Address
Glenn C Landon.	Payette Ida

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 7546

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Payette
City of Fruitland

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 32
(No. 47)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Gertrude Bossen.

(a) Residence. No. ____ St. ____
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	white	married.

6a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of P. D. Bossen.

6. DATE OF BIRTH (month, day and year) Dec 3 - 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	53		8	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work home wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER S. A. Delp.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Amanda Bonell

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iowa.

14. Informant (Address) O. E. Bossen. Payette. Idaho.

15. Filed Oct 14 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1930, to Oct 8, 1930, that I last saw h.. alive on Oct 5, 1930, and that death occurred, on the date stated above, at 4 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of breast—
Recurrence in chest—
ne 6 mos

(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? Microscopic

(Signed) E. E. Woodward M. D.
Oct 13, 1930 (Address) ____

19. Place of Burial, Cremation, or Removal	Date of Burial
Payette. Idaho.	Oct 13 1930
20. Undertaker Glenn C. Sanders	Address Payette Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED DEC 16 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 734

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 31
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Robert S. Reavis
(a) Residence. No. ..... St. 131
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Pearce Reavis

6. DATE OF BIRTH (month, day and year) Mar 14

7. AGE Years 74 Months Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) arkansas

PARENTS
10. NAME OF FATHER J. H. Reavis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown.
12. MAIDEN NAME OF MOTHER Ellen Carlyle.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) unknown.

14. Informant (Address) Claude Cartwright Payette Ida

15. Filed Oct 7 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1930, to Oct 6, 1930
that I last saw him alive on Oct 6, 1930
and that death occurred, on the date stated above, at 1:40 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cardiovascular renal disease

about (duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) Merrill R. Fox, M. D.
Oct 7, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal Midvale Idaho
Date of Burial 10-8 1930

20. Undertaker Glenn C Landon
Address Payette Ida

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73408

PLACE OF DEATH
County of Owyhee
City of Hot Springs

Registration District No. 74
Primary Registration District No. 2151
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 63

2. FULL NAME William Redman Strickland 74a

(a) Residence. No. Hot Springs Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 12-14-1845

7. AGE Years 84 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Stockman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa.

PARENTS
10. NAME OF FATHER William Strickland
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Illinois
12. MAIDEN NAME OF MOTHER Pence
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Will Strickland
(Address) Hot Springs Ida.

15. Filed Jan 1st, 1931. W J Eckenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11 (Month) 13 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14, 1930, to 11-13-1930 that I last saw him alive on Aug-20-1930 and that death occurred, on the date stated above, at 7.10A m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 6 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J E Evans, M. D.
12-18-1930 (Address) Mtn. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Hot Springs Ida. Date of Burial 11/16 1930

20. Undertaker G. S. Zacher Address Mt. Home Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7345

PLACE OF DEATH
County of Owyhee
City of Brunean Ida.
Registration District No. 74
Primary Registration District No. 2151
Local Registrar's No. 64
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Charles Edward Halverson 90

(a) Residence. No. ..... Brunean Ida. St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Susie Halverson.

6. DATE OF BIRTH (month, day and year): 2-19-1860

7. AGE — Years: 70 — Months: 9 — Days: 10 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Minn.

PARENTS

10. NAME OF FATHER: Henry
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Norway.
12. MAIDEN NAME OF MOTHER: Sarah Nightingale.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Minn.

14. Informant: Susie Halverson
(Address) Brunean Ida.

15. Filed Jan 12 1931. W J Eisenbeck Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) — 29 (Day) — 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1-, 1928, to 11-29-, 1930
that I last saw him alive on 11-18-, 1930
and that death occurred, on the date stated above, at 4.15 m.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation, + Enlargement of heart Muscle
..... (duration) 5 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) J E Emmons, M. D.
12-19-, 1930 (Address) Mtn. Home Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Brunean Ida — Date of Burial: 12-2 1930
20. Undertaker: G. E. Parker — Address: Mt Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½ M. 7-24-11 RECEIVED JAN 3 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 73410
Registered No. 49

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl F. Meredith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH: July (Month) - 19 (Day) - 1902 (Year)

7. AGE: 28 yrs. 6 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Restaurant Operator
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Salt Lake Utah

10. NAME OF FATHER: James Arthur Meredith

11. BIRTHPLACE OF FATHER (State or Country): Birmingham Eng.

12. MAIDEN NAME OF MOTHER: Rose Fellers

13. BIRTHPLACE OF MOTHER (State or Country): Berne Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Meredith
(Address) Beaver Utah

15.
Filed 12/31 1930 J. M. Kleen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1930, to Dec. 21 1930 that I last saw him alive on Dec. 21, 1930 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Scarlet fever

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Grant M. D.

Dec 23, 1930 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho
DATE OF BURIAL: Dec 23 1930

20. UNDERTAKER: J. Guy Benson
ADDRESS: Malad Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

RECEIVED JAN 3 1931

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 73411
Registered No. 48

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifford Jenkins Richards

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Child

6. DATE OF BIRTH: Oct. 27 1930 (Month) (Day) (Year)

7. AGE: ..... yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Malad Oda

10. NAME OF FATHER: Thos. Clifford Richards

11. BIRTHPLACE OF FATHER (State or Country): Malad Oda

12. MAIDEN NAME OF MOTHER: Lovisa Lae Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): Malad Oda

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clifford Richards
(Address) Malad Oda

15. Filed 12/31 1930 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH.

101B

16. DATE OF DEATH: Dec. 13 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1930 to Dec. 13 1930 that I last saw him alive on Dec. 13 1930 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Pneumonia & Convulsions

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) [illegible]

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M.D.

..... 19 ..... (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Oda
DATE OF BURIAL: Dec. 16 1930

20. UNDERTAKER: J. Guy Benson
ADDRESS: Malad Oda

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

RECEIVED JAN 5 1931

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2064

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 7343

Registered No. 47

1. PLACE OF DEATH.

County of Oneida

City of Malad

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Valene Parry

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 14 (Day) 1930 (Year)

7. AGE: ..... yrs. 9 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: Wilford E. Parry

11. BIRTHPLACE OF FATHER (State or Country): Afton Wyo.

12. MAIDEN NAME OF MOTHER: Mary H. Hughes

13. BIRTHPLACE OF MOTHER (State or Country): Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilford E. Parry
(Address) Malad Ida

15. Filed 1/3/31 1930 J. M. Kerns Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 11 (Day) 1000 A 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8 1930, to Dec. 11, 1930 that I last saw her alive on Dec. 11 1930 and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Complications (Toxic) due to some cerebral disturbance

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Grant M. D.

Dec 12, 1930 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: Dec 14 1930

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 1 RECEIVED JAN 3 1931 CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)
File No. 73413
Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Ronald Meredith

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: June (Month) - 6 (Day) 1930 (Year)

7. AGE: ..... yrs. 6 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad - Idaho

10. NAME OF FATHER: Earl F. Meredith

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake Utah

12. MAIDEN NAME OF MOTHER: Lettie Streeter

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Meredith
(Address) City

15. Filed 12/31 1930 J. M. Kenny Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) - 9 (Day) 1930 (Year) 100a

17. I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1930, to Dec. 9, 1930 that I last saw him alive on Dec. 9, 1930 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia (bronchial)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. P. Garst M. D.

Dec. 10, 1930 (Address) Malad, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho
DATE OF BURIAL: Dec. 11 1930

20. UNDERTAKER: J. Guy Benson
ADDRESS: Malad Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 4

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce Registration District No. 128

City of Spalding Idaho. Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ahtuns Mot Mot

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian 4/4

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Jan. (Month) 28 (Day) 1930 (Year)

7. AGE: Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Clarence Mot Mot

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Lizzie Scott

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Maxwell
(Address) Lapwai Idaho.

15.
Filed Sept 19 30 George Gaumard M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH 113

16. DATE OF DEATH: Sept (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 - 1930, to Sept 19 - 1930, that I last saw h.r. alive on Sept 19 - 1930, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Gastro - Enteritis

(Duration) yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Gaumard M. D.
9/19/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Idaho. DATE OF BURIAL: Sept 22 1930

20. UNDERTAKER: Brawner-Wann ADDRESS: Lewiston Idaho.

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Spalding or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Antonio Moj Mod

(a) Residence. No. Spalding, Ida St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: 1/4 Nez Perce Indian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1930

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS

10 NAME OF FATHER Clarence Mod Moj

11 BIRTHPLACE OF FATHER (city or town) Lapwai
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Lizzie Scott

13 BIRTHPLACE OF MOTHER (city or town) Spalding
(State or country) Ida

14 Informant Rev. Stark J. Maxwell
(Address) Lapwai Ida

15 Filed 9/20/, 1930 L. H. Maxwell
REGISTRAR

11—2184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 19, 1930, that I last saw h[illegible] alive on Sept. 19, 1930, and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:
Gastro-Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Gaugnard, M. D.
, 19 (Address) Clearwater, Idaho

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lapwai Cemetery	Sept 22 1930
20 UNDERTAKER	ADDRESS
Brown-Mann Co.	Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

f—209 d
V. S. No. 96

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. ____
Township ____ or Village Lapwai Vicinity or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ahtims Mox Mox

(a) Residence. No. Lapwai St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 1/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 28 1930

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai
(State or country) Idaho

PARENTS
10 NAME OF FATHER Clarence Mox Mox
11 BIRTHPLACE OF FATHER (city or town) Lapwai
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Lizzie Scott
13 BIRTHPLACE OF MOTHER (city or town) Spalding
(State or country) Ida

14 Informant Rev. Starr J. Mitchell
(Address) Lapwai Ida

15 Filed 9/20/, 1930 J. Mitchell
REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1930, to Sept. 19th, 1930, that I last saw her alive on Sept. 19, 1930, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:
Gastro Enteritis

____ (duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Lapwai Cemetery
DATE OF BURIAL: Sept. 22 19

20 UNDERTAKER: Brower-Winn Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1—200 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 19415

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 128

City of near Spalding — Primary Registration District No. Idaho

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leroy Pinkham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Indian 3/4	Infant

6. DATE OF BIRTH 1
(Month) (Day) (Year)

7. AGE 1 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Alexis Pinkham

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Annette Black Eagle

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annette Black Eagle
(Address) Spalding, Idaho.

15. Filed Nov. 1930 Geo. Gaumnitz Local Registrar

MEDICAL CERTIFICATE OF DEATH 31

16. DATE OF DEATH 11 (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-11-1930, to 11-29-1930, that I last saw him alive on 11-28-1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... yrs. 1 mos. 18 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaumnitz M. D.
11/29/1930 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lapwai Cemetery — DATE OF BURIAL Dec 1 1930

20. UNDERTAKER Grocer-Wann Co. — ADDRESS Lewiston Idaho

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96
2—20 d

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township ____ or Village Spalding Vicinity or
City ____ No. ____ St. ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME LeRoy Pinkham

(a) Residence. No. Spalding St., ____ Ward. ____
(Usual place of abode)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	4/4 Nez Perce Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9 BIRTHPLACE (city or town) Spalding
(State or country) Ida.

PARENTS

10 NAME OF FATHER LeRoy Pinkham
11 BIRTHPLACE OF FATHER (city or town) Mystic
(State or country) Ida.
12 MAIDEN NAME OF MOTHER Irma Blackeagle
13 BIRTHPLACE OF MOTHER (city or town) Spalding
(State or country) Ida.

14 Informant Lorsetta B. Pinkham Clerk
(Address) Kapowsin Wash.

15 Filed Dec. 1, 1930 M. Mantell REGISTRAR

11—3184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 29 19 30

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
____
____
____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) George Baugnard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Lebanon Cemetery	Dec. 1 1930
20 UNDERTAKER	**ADDRESS**
Brown-Wann Co	Lewiston

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 73417
Township Nez Perce Reservation or Village Lapwai or
City ~~Ft. Lapwai Indian Agency~~ Lapwai, Idaho No. No hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edith Leona Kane
(a) Residence. No. Lapwai St., Ward. 7
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 13, 1928

7 AGE: Years 2 | Months 4 | Days 5 | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lapwai Idaho

PARENTS
10 NAME OF FATHER: John Kane
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kamiah Ida
12 MAIDEN NAME OF MOTHER: Ellen Powke
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lapwai Idaho

14 Informant: John Kane - Father
(Address) Lapwai Ida

15 Filed Dec. 14, 1930 L. Maxwell
REGISTRAR

11—6184 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 18" 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1930, to Dec. 18, 1930, that I last saw her alive on Dec. 18, 1930, and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:
Measels
(duration) ---- yrs. ---- mos. 8 ds.

CONTRIBUTORY (SECONDARY) Broncho-pneumonia
(duration) ---- yrs. ---- mos. 2 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis? ✓

(Signed) George Gaignard, M. D.
12/27, 1930 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Cemetery
DATE OF BURIAL: Dec. 19 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1—200 d
V. S. No. 98

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 66

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

73418 Registered No.

1 PLACE OF DEATH
County Nez Perce State Idaho
Township Nez Perce Reservation or Village Spalding or
City Ft. Lapwai Indian Agency No. No hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)
Lapwai, Idaho.

2 FULL NAME Charles Jackson 134

(a) Residence. No. Spalding, Ida St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	4/4 Nez Perce Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Jackson

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	73			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) Invalid
(c) Name of employer

9 BIRTHPLACE (city or town) Kamiah
(State or country) Idaho

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Lewiston Morning Tribune
(Address) Lewiston Ida

15 Filed Dec 29, 1930 [illegible] REGISTRAR

11—6194 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1930, to Dec. 27, 1930, that I last saw him alive on Dec. 27, 1930, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:
Cholecystitis, and probably rupture of gall bladder.
12 hours (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18 Where was disease contracted ✓
If not at place of death?
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis?

(Signed) George Gaugnard, M. D.
12/31, 1930 (Address) Culdesac, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Spalding Cemetery	Dec 30 1930
20 UNDERTAKER	ADDRESS
Brown-Mann Co	Lewiston

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

73419

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township Nez Perce Reservation or Village Sweetwater or
City Ft. Lapwai Indian Agency No. No hospital St., Ward
Lapwai, Idaho.
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eugenia Guthrie

71B

(a) Residence. No. Sweetwater St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Guthrie

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 69 | Months — | Days — | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Spalding Idaho

PARENTS
10 NAME OF FATHER: Jesse Tenattakawenene
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kamiah Idaho
12 MAIDEN NAME OF MOTHER: Ahlalimuatsonmi
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweetwater Ida

14 Informant: Cecelia Guthrie Waters
(Address) Sweetwater Ida

15 Filed 12/29/1930 L. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Dec. 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1930, to Dec. 19, 1930, that I last saw her alive on Dec. 19, 1930, and that death occurred, on the date stated above, at ---- m.

The CAUSE OF DEATH* was as follows:
Tuberculous cerebro-spinal menigitis
(duration) ---- yrs. ---- mos. 21 ds.

CONTRIBUTORY (SECONDARY) ✓
(duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? ✓ Date of
Was there an autopsy? ✓
What test confirmed diagnosis? ✓

(Signed) George Gaignard, M. D.
12/27/1930 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Slickpoo Cemetery
DATE OF BURIAL: Dec. 22 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 26

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
13420

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township ____ or Village Lapwai Vicinity or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Maggie Timothy

(a) Residence. No. ____ Lapwai St., ____ Ward. 205-13
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	1/4 Nez Perce Indian	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	89	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reserve
(State or country) Idaho

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) "
(State or country) "
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Leorlette B. Lawyer-Clerk
(Address) Lapwai, Ida.

15 Filed Nov. 16, 1930 J. M. Maxwell
REGISTRAR

11—6194

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from
____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____ m.
The CAUSE OF DEATH* was as follows:
No physician in attendance
____
____
____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY ____
(SECONDARY)
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted
if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____
(Signed) ____, M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Spalding Cemetery	Nov. 17 1930
20 UNDERTAKER	ADDRESS
Brower-Nannis	Lewiston

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

73421

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai Vicinity or
City No. , St. Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Tahmahwenunmy 52
(a) Residence. No. Lapwai St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lowry

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 69 | Months | Days | If LESS than 1 day, ---- hrs. or ---- min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Nez Perce Reserve Ida.

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): "
12 MAIDEN NAME OF MOTHER: "
13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Corbett B. Lawyer Clerk
(Address) Lapwai Ida.

15 Filed Nov. 15, 1930 L. M. Maxwell REGISTRAR

11—6134 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-18-, 1930, to 10-21, 1930, that I last saw her alive on 10-21, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Rheumatism
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Myocarditis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
, 19 (Address) Culdesac, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Spalding Cemetery
DATE OF BURIAL: Nov. 18 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

73422

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No.
Township or Village Lapwai or
City No. , St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elijah Red Elk
(a) Residence. No. Lapwai St., Ward. 185
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Weyahtulwatsonmy

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE

Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
61	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Nez Perce Reserve
(State or country) Idaho

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Corbett B. Lawyer-Clerk
(Address) Lapwai, Ida

15 Filed Oct. 29, 1930 L. M. Maxwell
REGISTRAR

11—8194 GOVERNMENT PRINTING OFFICE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from
, 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Fall causing fracture of the Cervical Vertebra
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) , M. D.
, 19 (Address)

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Lapwai Cemetery
DATE OF BURIAL: Nov. 1 1930

20 UNDERTAKER: Brower-Wann Co
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1543

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Elsie Marie Rogers.

(a) Residence. No. St. Spalding, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 21st, 1926.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4.	3.	6.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Genesee,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER L. C. Rogers.
11. BIRTHPLACE OF FATHER (city or town) Dayton,
(State or Country) Wash.
12. MAIDEN NAME OF MOTHER Flora B. Wilson.
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Tenessee.

14. Informant L. C. Rogers.
(Address) Spalding, Idaho.

15. Filed , 19 .
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December 27th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec 17, 1930, to Dec 27th, 1930
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Central Lobar Pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death? Lapwai Idaho
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Samples Laboratory +
(Signed) Physician sign O. C. Carnegie, M. D.
12/30/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/30/30. 19
20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73424

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 207 Snakeriver Avenue.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Margery Jane Torvill.

(a) Residence. No. 207 Snakeriver Avenue. St. 97
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Single.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) December 13th, 1929.

7. AGE: Years 1. Months ----- Days 15. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lewiston, Idaho.

PARENTS

10. NAME OF FATHER: Chester Torvill.

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Hazel McAllister.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Anatone, Washington.

14. Informant: Mrs C. Torvill.
(Address) Lewiston, Idaho.

15. Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 28th, 1930. 19..
(Month) (Day) (Year)
Dec 25 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 25, 1930, to Dec 28, 1930 that I last saw her alive on Dec 25, 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Acute ulcerative tonsilitis

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

Same (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis? Cardinal Symptoms

(Signed) E. L. White, M. D.

12/29/30., 19.... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho.
Date of Burial: 12/29/30. 19

20. Undertaker: Brower-Wann Company,
Address: Lewiwston, Idah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73425

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. 11 Kimbell Court.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931 160

2. FULL NAME Leo James.

(a) Residence. No. 11 Kimbell Court. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	Indian.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dedember 15th, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
----	----	12.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lewiston, Idaho.

PARENTS

10. NAME OF FATHER Jones James.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Ida Whitebird.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Idaho.

14. Informant Jones James
(Address) Lewiston, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 27th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from, 19 to attending 19
that I last saw alive on 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Probably Malnutrition Baby very small & weak at birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Pyle, M. D.

12/27/30, 19 (Address) Lewiston. Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Ahsahka, Idaho.	19
20. Undertaker	**Address**
Prower-Vann Company.	Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73426

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. R. R. Yard house.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931 90

2. FULL NAME Leland Weaver.

(a) Residence. No. St. Clarkston, Washington.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) 1/16/1870.

7. AGE: Years 60. Months 11. Days 13. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: R. R. Passenger Conductor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Freemont, Nebraska.

PARENTS

10. NAME OF FATHER: John Weaver,

11. BIRTHPLACE OF FATHER (city or town) (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Penn.

14. Informant

(Address) Clarkston, Washington.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 29th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28th, 1930, to Dec 29th, 1930

that I last saw him alive on Dec 29th 1930

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chr Interstitial Nephritis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Laboratory

(Signed) O C Carlsson, M. D.

12/31/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Spokane, Washington. Date of Burial 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73427

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Vanda Osborne.

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4.			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Albuquerque, N. M.

PARENTS

10. NAME OF FATHER W. C. Osborne,

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Mary Johnson.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ky.

14. Informant W. C. Osborne
(Address) Lewiston, Idaho.

15. Filed , 19 .
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 6th, 1930. 119
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1930, to Oct 6, 1930
that I last saw her alive on Oct 6, 1930
and that death occurred, on the date stated above, at 11 a. m.
The CAUSE OF DEATH* was as follows:

Ileocolitis (membranous)

(duration) yrs. mos. 30 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) E. G. Bradford, M. D.

10/6/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Near Winchester, Idaho.	10/7/30. 19
20. Undertaker	Address
None.	

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 10345

PLACE OF DEATH
County of Nez Perce.
City of .....

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

74a

RECEIVED JAN 12 1931

2. FULL NAME Nels Peter Skow.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 9/13/1857.

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
73.	2.	20.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10. NAME OF FATHER Peter Skow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark.
12. MAIDEN NAME OF MOTHER Not known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Nels Skow
(Address) Lapwai, Idaho.

15. Filed ....., 19.... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 3rd, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
....., 19...., to ....., 19....
that I last saw h..... alive on ....., 19....
and that death occurred, on the date stated above, at 4:15 P m.
The CAUSE OF DEATH* was as follows:
apoplexy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) Em Brower Coroner, M.D.
12/8/30., 19.... (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/5/30. 19

20. Undertaker	Address
Brower-Vann Company.	Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Black

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7348

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St Joseph Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME James L. Dick.

(a) Residence. No. Close In Apts. St. 88a
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 15th, 1865.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65.	7.	20.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Philadelphia, Penn.

PARENTS

10. NAME OF FATHER James Dick.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Philadelphia, Penn.
12. MAIDEN NAME OF MOTHER Martha Griffith,
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Philadelphia, Penn.

14. Informant Mr. J. L. Dick.
(Address) Lewiston, Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 5th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 5, 1930
that I last saw him alive on Dec 5, 1930
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:
Endocarditis (Septic)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. O. Clark, M. D.
12/6/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/7/30. 19

20. Undertaker	Address
Brower-Vann Company,	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73431

Registration District No.
Primary Registration District No.
Local Registrar's No.

PLACE OF DEATH

County of Nez Perce.
City of Lewiston.
(No. 232 3rd, Street.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME Arthur Frederick Lewis.

(a) Residence. No. 232 3rd, Street. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb. 19th, 1858.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.	9.	20.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Secretary Building & Loan Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lewiston Saving and Loan Association.

9. BIRTHPLACE (city or town) McClements,
(State or country) Michigan.

PARENTS

10. NAME OF FATHER George F. Lewis.

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) Mass.

12. MAIDEN NAME OF MOTHER Mary Robertson.

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Michigan.

14. Informant Mrs. A. F. Lewis.
(Address) Lewiston, Idaho.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

107

16. DATE OF DEATH December 9th, 1930.
(Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th, 1930, to Dec 9th, 1930
that I last saw him alive on Dec 9th, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Pulmonary Odema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs

(Signed) O. C. Carlson, M. D.
12/12/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/12/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

"Haury"

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73452

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 12 1931
205 B

2. FULL NAME Francis M. Ghoomley
(a) Residence. No. 307 - 17th st. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 12 1849

7. AGE Years 81 Months 1 Days 28 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wis

PARENTS
10. NAME OF FATHER dont know
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Virgil M. Ghoomley
(Address) Lewiston Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from On Dec 11, 1930 to , 19
that I last saw him alive on - never seen above
and that death occurred, on the date stated above, at Died about 12 45 A.m.
The CAUSE OF DEATH* was as follows: unknown
Called for first time after patient had been dead 30 mi. or more
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) Paul G. Hasing M. D.
12/12, 1930 (Address) Lewiston Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 12/12 1930

20. Undertaker Passar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

White

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73433

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

Local Registrar's No.

(No. Whites Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

111a

2. FULL NAME Edwin Lee Beachman.

(a) Residence. No. St. Clarkston, Washington.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Dot Beachman.

6. DATE OF BIRTH (month, day and year) September 8th, 1895.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35.	3.	4.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fruit Packer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas.

PARENTS

10. NAME OF FATHER Lee Beachman.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Evelyn Taylor.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mt Vernon, Illinois.

14. Informant Eugene Beachman
(Address) Clarkston, Washington.

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/11-30, 19, to 12/12-30, 19
that I last saw him alive on 12/12-30, 19
and that death occurred, on the date stated above, at 6 30 p. m.
The CAUSE OF DEATH* was as follows:
Ruptured gastric ulcer.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 12/11-30.

Was there an autopsy? Yes

What test confirmed diagnosis? Signs + symptoms

(Signed) Edgar L White, M. D.

12/14/30. 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/15/30. 19

20. Undertaker	Address
Brower-Wann Company.	Lewiston, Idaho.

Lyle

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73423

PLACE OF DEATH

County of Nez Perce.

City of Lewiston.

Registration District No.

Primary Registration District No.

(No. St Joseph Hospital.) RECEIVED JAN 12 1931

Local Registrar's No. 1613

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Baby Boyer.

(a) Residence. No. St. Mohler, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) December 16th, 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or
--------	----	----	30 min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston,
(State or country) Idaho.

PARENTS

10. NAME OF FATHER Charles S. Boyer.

11. BIRTHPLACE OF FATHER (city or town) Leland,
(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Mabel Smith.

13. BIRTHPLACE OF MOTHER (city or town) Spokane,
(State or Country) Washington.

14. Informant Chas. S. Boyer.
(Address) Mohler, Idaho.

15. Filed ....., 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 16th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1930, to Dec-16, 1930
that I last saw h[illegible] alive on Dec-16-, 1930
and that death occurred, on the date stated above, at 10-45a m.
The CAUSE OF DEATH* was as follows: Injury at birth.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Lyle, M. D.

12/17/30., 19 (Address) Lewiston, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston, Idaho.	12/17/30. 19
20. Undertaker	Address
Brower-Mann Company.	Lewiston, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73455

RECEIVED JAN 12 '31

PLACE OF DEATH
County of Nezperce
City of Lewiston, Ida.
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. .....
(No. Whites Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Clinton Clark

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Nellie Hunscker

6. DATE OF BIRTH (month, day and year) April 5th, 1893

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mt. Hope, Washington

PARENTS

10. NAME OF FATHER George W. Clark

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Morrow Co. Ill.

12. MAIDEN NAME OF MOTHER Laura Rney

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Walter Co. Ill

14. Informant (Address) Mrs Geo W Clark (Mother) Clarkston, Wash.

15. Filed ....., 19..... .....
Registrar.

MEDICAL CERTIFICATE OF DEATH 88W

16. DATE OF DEATH Dec 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/16-30, 19..... to 12-17-30, 19.....
that I last saw h[illegible] alive on 12/17-1930, 19.....
and that death occurred, on the date stated above, at [illegible] m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute endocarditis

.....(duration) .....yrs. .....mos. 2 ds.

CONTRIBUTORY .....
(Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Signs and symptoms
(Signed) J. H. Poole M.D., M. D.
12/18-30, 19..... (Address) Lewiston, Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Nezperce Idaho	12/20/30 19

20. Undertaker H. R. Merchant Address Clarkston Wn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73437

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No.
Primary Registration District No.
(No. St Joseph Hospital)
Local Registrar's No. 127
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 12 1931

2. FULL NAME James Nejheagle
(a) Residence, No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Indian	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct 30 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Lewiston Idaho
(State or country)

PARENTS

10. NAME OF FATHER A. Nejheagle
11. BIRTHPLACE OF FATHER (city or town) Tewetwater Idaho
(State or Country)
12. MAIDEN NAME OF MOTHER Billy Lake
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or Country)

14. Informant A. Nejheagle
(Address) Lapwai Idaho

15. Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 23 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30, 1930 to Dec 23, 1930
that I last saw him alive on Dec 22, 1930
and that death occurred, on the date stated above, at 2-30 A m.
The CAUSE OF DEATH* was as follows:
acute indigestion
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Premature Baby 7 mos
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? St Jos Hosp
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Paul W Johnson M. D.
Dec 23, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kamiah Idaho	12/23 1930
20. Undertaker	Address
Sassar Mortuary	Lewiston Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73437

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. 1323 - Idaho St.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 1 2 19[illegible]

2. FULL NAME Joseph A Bly
(a) Residence No. 1323 - Idaho St. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs J A Bly.

6. DATE OF BIRTH (month, day and year) Nov 24 1855

7. AGE Years 75 Months — Days 30 If LESS than 1 day, ___ hrs. or ___ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Joe Bly.
(Address) Rogersburg Ore.

15. Filed 12-27, 1930 J. M. Lyle By N.B. Registrar

MEDICAL CERTIFICATE OF DEATH 90

16. DATE OF DEATH Dec. (Month) 25 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend, 19__
that I last saw him alive Did not see him alive, 19__
and that death occurred, on the date stated above, at 6:30 p m.
The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Unknown. arteriosclerosis.
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
12-27, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho. Date of Burial 12/27 1930

20. Undertaker Vassar Mortuary Inc Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73438

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1009
(No. Lewiston Orchards.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

RECEIVED JAN 12 1931

2. FULL NAME Geraldine Warren
(a) Residence. No. Lewiston Orchards. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Jan 22 - 1930
7. AGE Years — Months 11 Days 3 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Lewiston

PARENTS
10. NAME OF FATHER G. B. Warren
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mo.
12. MAIDEN NAME OF MOTHER Anna Smith
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Mo.

14. Informant G. B. Warren
(Address) Lewiston Orchards.

15. Filed 12-27, 1930 J. M. Lyle By N. B. Registrar

MEDICAL CERTIFICATE OF DEATH 1000

16. DATE OF DEATH Dec. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1930, to Dec. 25, 1930
that I last saw her alive on Dec. 25, 1930
and that death occurred, on the date stated above, at 8 A.M. m.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(duration) yrs. mos. 10 ds.
CONTRIBUTORY (Secondary) Measles
(duration) yrs. mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phy. Sec. assigns
(Signed) J. M. Lyle M. D.
12-27 1930 (Address) Lewiston

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Lewiston Idaho
Date of Burial 12/28 1930
20. Undertaker Vassar Mortuary Inc
Address Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73439

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. ..... Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lucy V Campbell

RECEIVED JAN 12 1931

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 1853 Jan 9

7. AGE 78 Years | Months 11 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rockford Ill

PARENTS
10. NAME OF FATHER A Campbell
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Rutland Vermont
12. MAIDEN NAME OF MOTHER Lydia Shepard
13. BIRTHPLACE OF MOTHER (city or town) (State or County) New Malburn Mass.

14. Informant (Address) Lillian Campbell Clarkston Wash

15. Filed 12-20, 1930 J M Lyle Registrar.

MEDICAL CERTIFICATE OF DEATH 100a

16. DATE OF DEATH Dec - 19 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec - 16, 1930, to Dec - 19 - 1930
that I last saw her alive on Dec 19, 1930
and that death occurred, on the date stated above, at 10-35a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Broncho pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) J M Lyle, M. D.
12-20, 1930 (Address) Lewiston

19. Place of Burial, Cremation, or Removal Clarkston Wn | Date of Burial 12-26 1930

20. Undertaker H. R. Merchant | Address Clarkston Wn

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73441

PLACE OF DEATH
County of Nez Perce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1004
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Jesse Hall
(a) Residence. No. Boise Idaho. St. Boise Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dont know

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10. NAME OF FATHER " "
11. BIRTHPLACE OF FATHER (city or town) (State or Country) " "
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Records White Hospital
(Address)

15. Filed 12-27, 1930 J. M. Lyle Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH Dec. 21 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1930, to Dec 21, 1930
that I last saw him alive on Dec 21 - 1930
and that death occurred, on the date stated above, at 5:15 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy.
(Cerebral Hemorrhage)
(duration) yrs. mos. 21 ds.
CONTRIBUTORY (Secondary) Arterio sclerosis & hypertension
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Cardinal Symptoms
(Signed) E. L. White, M. D.
12-27, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Idaho	12/26 1930
20. Undertaker Casper Mortuary Inc.	Address Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 1341

PLACE OF DEATH
County of Nez Perce
City of Lewiston

Registration District No. 96
Primary Registration District No. 1909
(No. White Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Dr Susan E. Bruce

RECEIVED JAN 12 1931

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	white	widow

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 15 - 1848

7. AGE	Years	Months	Days	If LESS than 1 day,
	82	4	9	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Doctor M.D.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) New Brunswick Canada

PARENTS

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (city or town) (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) —

14. Informant Hospital
(Address) Lewiston Ida.

15. Filed 2-27, 1930 J. M. Lyle By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH 129

16. DATE OF DEATH Dec 24 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ July 1, 1930, to Dec 24, 1930
that I last saw her alive on Dec 24 1930
and that death occurred, on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows: Chronic interstitial nephritis

(duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) arterio-sclerosis
(duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical symptoms
(Signed) E. L. White, M. D.
12-27, 1930 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Lewiston Ida	12/26 1930
20. Undertaker	Address
Vassar Mortuary Inc	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

1. PLACE OF DEATH

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

County of Nez Perce — Registration District No. 128
City of Spalding Idaho — Primary Registration District No.
(No. ..... St.)
State File No. 4442
Local Registrar's No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Indian 4/4	Widowed

6. DATE OF BIRTH ..... (Month) ..... (Day) 1857 (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF Father Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewiston Morning Tribune
(Address) Lewiston Idaho.

15.
Filed Dec 1930 George Gaymard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 133

16. DATE OF DEATH Dec (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1930, to Dec 27 1930, that I last saw him alive on Dec 27 1930, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Cholecystitis and Probably Rupture of Gall bladder
12 hours (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaymard M. D.
12/31/1930 (Address) Cuddeback Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Spalding Cemetery — DATE OF BURIAL Dec 30 1930

20. UNDERTAKER Brauer-Wann — ADDRESS Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Gaignard

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 13445

PLACE OF DEATH

County of Nez Perce.

City of Sweetwater.

Registration District No. 128

Primary Registration District No.

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Shoemaker.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. Single, Married, Widowed, or Divorced (write the word): Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) March 4th, 1854.

7. AGE Years: 76. Months: b 9. Days: 10. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retiered farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Illinois.

PARENTS

10. NAME OF FATHER Not known.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known.

14. Informant Harry Shoemaker
(Address) Sweetwater, Idaho.

15. Filed , 19 . Registrar

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH December 14th, 1930. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-8-29, 19 , to 12-14-, 1930
that I last saw him alive on 12-14-, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) 1 yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George Gaignard, M. D.
12/15/30. 19 (Address) Culdesac, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Lewiston, Idaho. Date of Burial: 12/16/30. 19

20. Undertaker: Brower-Wann Company. Address: Lewiston, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Guard

RECEIVED JAN 1 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73446

PLACE OF DEATH
County of Nez Perce
City of Sweetwater

Registration District No. 128
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Joseph Foster 131
(a) Residence. No. Sweetwater St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Foster

6. DATE OF BIRTH (month, day and year) Oct 1862

7. AGE Years 68 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Rancher.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Austria

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant Vera Foster
(Address) Sweetwater

15. Filed Nov, 1930 George Gaignard M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 5th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2:30 P. m.
The CAUSE OF DEATH* was as follows:
Brights Disease and Dropsy
(duration) 4 yrs. mos. ds.
CONTRIBUTORY (Secondary) Dropsy
(duration) yrs. 4 mos. ds.

18. Where was disease contracted if not at place of death? No Medical attendance in past year
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) George Gaignard, M. D.
4/6/30, 19 (Address) Culdesac Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mission
Date of Burial 11/7 1930

20. Undertaker Brewer-Wann
Address Lewiston Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of near Culdesac

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 73447

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patricia Ann Wittman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 2 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: George Wittman

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Clara Weber

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlotte Wittman
(Address) Culdesac Idaho.

15. Filed Dec 1930 George Gaignard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH 80

16. DATE OF DEATH: 12 (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Found dead in bed in the morning. Probably died in convulsions as child was well night before

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaignard M. D.

12/20/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Vassar Mortuary Inc.

ADDRESS: Lewiston, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Nez Perce

City of Culdesac Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128

Primary Registration District No.

(No. ..... St.)

State File No. 7348

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geraldine Bateman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6. DATE OF BIRTH: Nov. (Month) 26 (Day) 1925 (Year)

7. AGE: 4 Yrs. 9 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF Father: Glen Bateman

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Gladys Brown

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Myrel Bateman
(Address): Culdesac Idaho

15. Filed Sept 1930 George Gaymond Local Registrar

MEDICAL CERTIFICATE OF DEATH 114

16. DATE OF DEATH: Sept (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-30-1930, to 9-8-1930, that I last saw h.. alive on 9-8-1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Gastro-Enteritis

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaymond M. D.
Sept 1, 1930 (Address) Culdesac Idaho.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Idaho — DATE OF BURIAL: 9-10-1930

20. UNDERTAKER: Family — ADDRESS: Culdesac Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 73449

Local Registrar's No.

1. PLACE OF DEATH

County of Nez Perce Registration District No. 128

City of Culdesac (or near) Idaho Primary Registration District No.

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Annie Marshall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6. DATE OF BIRTH: April (Month) 9 (Day) 1867 (Year)

7. AGE: 63 Yrs. 6 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF Father: John Groos

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Matilda Calhoun

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. M. Hewett
(Address) Culdesac Idaho.

15. Filed Nov 1930 George Gaymard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 - 1930, to Nov 5 - 1930, that I last saw her alive on Nov 5 - 1930, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaymard M. D.

11/5/1930 (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho. DATE OF BURIAL: Nov. 7 1930

20. UNDERTAKER: Brower-Wann ADDRESS: Lewiston Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. RECEIVED JAN 7 1931 CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 74 73450
Local Registrar's No. 74

1. PLACE OF DEATH
County of Minidoka Registration District No. 19
City of Paul Primary Registration District No. 2015
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira J. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

6. DATE OF BIRTH
..... (Month) ..... (Day) 1860 (Year)

7. AGE
70 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF Father E. L. Brown

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Caroline Farley

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eth Brown
(Address) Paul Idaho

15.
Filed Jan. 5 1931 Eth Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart failure
.....
.....
.....(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Goodman Coroner M. D.
19..... (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Paul Cemetery | DATE OF BURIAL ..... 19.....

20. UNDERTAKER W. A. Goodman | ADDRESS Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 1-26 M. 1-19. JAN 7 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Cassia

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19K

Primary Registration District No. 2016

(No. ..... St.)

State File No. 73453

Local Registrar's No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Christensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1885 (Year)

7. AGE: 45 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF Father: Christen Larson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Caroline Larson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Christensen
(Address) Rupert Idaho

15. Filed Jan 5 1931 Elt Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

49

16. DATE OF DEATH: Nov (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3, 1930, to Nov. 5, 1930, that I last saw her alive on Nov. 5, 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kenagy M. D.

1-5, 1931 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery

DATE OF BURIAL: Nov 11 1930

20. UNDERTAKER: W. A. Goodman

ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 13454

Local Registrar's No. 28

1. PLACE OF DEATH JAN 7 1931

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2019

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Velma Ruth Catmul

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Child

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1930 (Year)

7. AGE: Yrs. 1 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Alvin E Catmul

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Adaline Whittle

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alvin E Catmul
(Address): Rupert Idaho

15.
Filed Jan. 5 1931 E. V. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH 1013

16. DATE OF DEATH: Nov (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1930, to Nov. 7, 1930, that I last saw her alive on Nov. 7, 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kenagy M. D.

1-5, 1931 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery I. D. | DATE OF BURIAL: Nov 9 1930

20. UNDERTAKER: W. G. Gudmundsen | ADDRESS: Rupert Idaho

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

JAN 7 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 7945

PLACE OF DEATH
County of Minidoka
City of Rupert
Registration District No. 19
Primary Registration District No. 2015
(No.)
Local Registrar's No. 79

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Vera H Orr ORR

170

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 10 1904

7 AGE: Years 37 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Idaho

PARENTS
10 NAME OF FATHER: John C Martindale
11 BIRTHPLACE OF FATHER (city or town) (State or country): Utah
12 MAIDEN NAME OF MOTHER: Ida Lee
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Utah

14 Informant: Ida Martindale
(Address): Burley Idaho

15 Filed Jan 5, 1931 A W Skinner Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 7 (Day) 1931 (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19, to , 19,
that I last saw h alive on , 19,
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Pistol Shot Thru chest
cutting Aortic Artery
Probably self inflicted.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy

(Signed) A W Skinner M. D.
1 — 5, 1931 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Burley Cemetery
Date of Burial: Sept 10 1931

20. Undertaker: W. G. Gardner
Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 19
Primary Registration District No. 2013
(No. ..... St.)

State File No. 1245
Local Registrar's No. 80

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Minidoka
City of Rupert

2. FULL NAME Mary Jane Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) Widow

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1853 (Year)

7. AGE: 77 Yrs. 11 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF Father: Pittman

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Myrtle Bowman
(Address): Rupert Idaho

15.
Filed Jan 5 1931 E M Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH 57

16. DATE OF DEATH: Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1928 19.., to Oct 19 1930, that I last saw her alive on Oct 19 1930, and that death occurred on the date stated above, at 10 45 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) E M Elmore M. D.

1-5 1931 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery — DATE OF BURIAL: Oct 21 1930

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert Idaho

RECEIVED JAN 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 2345

Local Registrar's No. 81

PLACE OF DEATH
County of Minidoka
City of Rupert

Registration District No. 19
Primary Registration District No. 2013
(No.)

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Hilda F Swarlingen

(a) Residence. No. 1430 St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	6	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10 NAME OF FATHER Benj F Fitzpatrick
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER Harriett Spidell
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa

14 Informant Marion C Fitzpatrick
(Address) Weiser Idaho

15 Filed Jan 5, 1931 E B Elmore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 22 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1930, to Aug. 22, 1930, that I last saw her alive on Aug 22, 1930, and that death occurred, on the date stated above, at 3:25 P m.

The CAUSE OF DEATH* was as follows:
Septicaemia, General
(duration) yrs. mos. ds.
CONTRIBUTORY Abortion
(Secondary)
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? General septicemia
(Signed) E B Elmore, M. D.
1-5, 1931 (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Rupert Cemetery — Date of Burial: Aug 24 1930
20. Undertaker: W. J. Goodman — Address: Rupert Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sutherland

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73459

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2174
Local Registrar's No. 72

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Gola Mae McKenna

(a) Residence. No. C St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	W.	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 13th 1930.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Rexburg Ida.

PARENTS

10. NAME OF FATHER R. B. McKenna
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Logan Utah.
12. MAIDEN NAME OF MOTHER Olive Gilling.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mt Pleasant Utah

14. Informant (Address) R. B. McKenna Rexburg Ida.

15. Filed Jan 2 1931 Registrar

MEDICAL CERTIFICATE OF DEATH 2057B

16. DATE OF DEATH Dec 25th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
— 19..., to — 19...
that I last saw h... alive on — 19...
and that death occurred, on the date stated above, at 9 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Unknown - Infant was dead before Delivered - Probably some heart disturbance

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? —

(Signed) W. H. Sutherland, M. D.
12-4 1930 (Address) Rexburg, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg Ida.	Dec. 27 1930
20. Undertaker	Address
Vern J. Keller	Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Dr Rich

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73460

PLACE OF DEATH
County of Madison
City of Burton

Registration District No. 100
Primary Registration District No. 2 77 Local Registrar's No. 77
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Minnie Weber Beck
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 21 - 1864

7. AGE Years 64 Months 7 Days 4 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10. NAME OF FATHER Chris Ludwid Webber
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Dorothea Stiefel
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany

14. Informant (Address) Rosa Nauer

15. Filed Jan 2, 1931 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH 57

16. DATE OF DEATH Dec. (Month) 25th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1924, to Dec 25, 1930
that I last saw her alive on Dec 20, 1930
and that death occurred, on the date stated above, at 7 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Diabetes mellitus

(duration) 9 yrs. mos. ds.
CONTRIBUTORY (Secondary) Gangrene of feet
(duration) yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Norm F. Rich, M. D.
Dec 30, 1930 (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal Rexburg, Idaho
Date of Burial Dec. 30 1930

20. Undertaker Vern J. Keller
Address Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Madison
City of Teton

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 76
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Val. Henry Riggs
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 25th 1930

7. AGE Years | Months 3 | Days 29. | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Teton
(State or country) Ida.

PARENTS
10. NAME OF FATHER Henry Riggs
11. BIRTHPLACE OF FATHER (city or town) Teton
(State or Country) Ida
12. MAIDEN NAME OF MOTHER Florence Busby
13. BIRTHPLACE OF MOTHER (city or town) Driggs
(State or County) Ida

14. Informant (Address) Ursel Riggs Teton

15. Filed Jan 2 1930 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH 101B

16. DATE OF DEATH Dec (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Dec 24, 1930
that I last saw him alive on Dec 4, 1930
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H B Rigby, M. D.
Dec 24, 1930 (Address) Rexburg, Ida.

19. Place of Burial, Cremation, or Removal Teton Ida. | Date of Burial Dec 27 1930

20. Undertaker Vern J Keller | Address Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73462

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 75
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Reu. Kloi Meservy

RECEIVED JAN 8 1931

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.)

5a. If married, widowed, or divorced
~~HUSBAND~~ of
~~(or) WIFE~~ of

6. DATE OF BIRTH (month, day and year) Sept. 17th 1929.

7. AGE Years 1. Months 3 Days 6. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Rexburg
(State or country) Idaho.

PARENTS

10. NAME OF FATHER O. K. Meservy.
11. BIRTHPLACE OF FATHER (city or town) Utah
(State or Country)
12. MAIDEN NAME OF MOTHER C. Eleanor Bagley.
13. BIRTHPLACE OF MOTHER (city or town) Idaho
(State or County)

14. Informant (Address) O. K. Meservy. St Anthony Route #1.

15. Filed Jan 2, 1930 J R Young Registrar

MEDICAL CERTIFICATE OF DEATH 9

16. DATE OF DEATH Dec. (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1930, to Dec. 23, 1930
that I last saw him alive on Dec. 23, 1930
and that death occurred, on the date stated above, at 7 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Whooping Cough.
Convulsion (Eight)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) B B Rigby M. D.
Dec. 26, 1930 (Address) Rexburg Ida.

19. Place of Burial, Cremation, or Removal Wilford Ida. Date of Burial Dec 24 1930

20. Undertaker Vern J Keller Address Rexburg

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73463

PLACE OF DEATH
County of Madison
City of Salem

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 74
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. **FULL NAME** Neils Rasmussen

(a) Residence. No. Salem Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 6th 1851

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	II	I6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Rasmus Neilsen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant Wells Rasmussen
(Address) Salem Idaho.

15. Filed Jan 2, 1931 Registrar

MEDICAL CERTIFICATE OF DEATH 164

16. DATE OF DEATH Dec 20 (Month) Saturday (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19.....
and that death occurred, on the date stated above, at.....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility
Arteriosclerosis

.....(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. B. Rigby, M. D.
Dec 23, 1930 (Address) Rexburg

19. Place of Burial, Cremation, or Removal	Date of Burial
Sugar City	Dec. 23-1930

20. Undertaker Vern J. Keller Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73464

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178 Local Registrar's No. 73
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME John Fredrich Dieterle
(a) Residence. No. 264 S 2nd West St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

JAN 8 1931

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~

6. DATE OF BIRTH (month, day and year) May 10th 1862

7. AGE Years 68 Months 7 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Garrweiler Wittenberg Germany.

PARENTS

10. NAME OF FATHER Jacob Fredrich Dieterle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Garrweiler Wittenberg Germ.
12. MAIDEN NAME OF MOTHER Magedelena Kay
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grunbach Wittenberg Germany

14. Informant (Address) Mrs John Dieterle Rexburg

15. Filed Jan 21, 1930 J R Young Registrar.

MEDICAL CERTIFICATE OF DEATH 128

16. DATE OF DEATH Dec. (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1930, to Dec. 18, 1930
that I last saw him alive on Dec. 18, 1930
and that death occurred, on the date stated above, at 9:45 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(duration) yrs. mos. 15 ds.
CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? /
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? no
(Signed) A H Sutherland, M. D.
12-18, 1930 (Address) Rexburg, Ida.

19. Place of Burial, Cremation, or Removal Rexburg
Date of Burial 12/22 1930

20. Undertaker Russel Flamm
Address Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73465

PLACE OF DEATH
County of Madison
City of Rexburg
Registration District No. 100
Primary Registration District No. 2178
Local Registrar's No. 72
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME Mary Phylis Richman

(a) Residence. No. ..... Rexburg, Idaho. ..... St.
(Usual place of abode)
Length of residence in city or town where death occurred. ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Dec. 6th, 1930

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
XXXXX	XXXX	One	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) Rexburg, Idaho.
(State or country)

PARENTS

10. NAME OF FATHER John Richman
11. BIRTHPLACE OF FATHER (city or town) Clarkston, Utah
(State or Country)
12. MAIDEN NAME OF MOTHER Myrtle Stewart
13. BIRTHPLACE OF MOTHER (city or town) Paradise, Utah.
(State or Country)

14. Informant John Richman
(Address) Rexburg, Idaho.

15. Filed Jan 2, 1931 R Young Registrar

MEDICAL CERTIFICATE OF DEATH 148

16. DATE OF DEATH Dec. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6, 1930, to Dec. 8, 1930
that I last saw her alive on Dec. 8, 1930
and that death occurred, on the date stated above, at 2:10 m.
The CAUSE OF DEATH* was as follows:
Toxemia from mother.
(Mother had kidney disease.)
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) R. B. Young, M. D.
Dec 12, 1930 (Address) Rexburg

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Teton Cemetery	Dec. 8th, 1930

20. Undertaker F. M. Hansen Address St. Anthony, Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. [illegible]
Primary Registration District No. 2-25
(No. 74 St.)

State File No. [illegible]
Local Registrar's No. 71
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marlin G. Jones

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): infant.
6. DATE OF BIRTH: Sept (Month) 27 (Day) 1930 (Year)
7. AGE: Yrs. Mos. 2 ds. 8
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Rexburg Idaho
10. NAME OF Father: James L. Jones
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Frenetta Hayes
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James L. Jones
(Address) Rexburg Idaho
15.
Filed Jan 2 1931 J. R. Symms Local Registrar

MEDICAL CERTIFICATE OF DEATH 162

16. DATE OF DEATH: December (Month) 5-th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 4 1930, to Dec 5 1930, that I last saw h/me alive on Dec 5 1930, and that death occurred on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:
Premature
(Duration) yrs. mos. 30 ds.
Contributory Malnutrition
(Secondary)
(Duration) yrs. mos. ds.

12/6 1930 (Signed) Louis F. Richo M. D.
(Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City Cemetery — DATE OF BURIAL: 12/8 1930
20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73467

PLACE OF DEATH
County of Madison
City of Rexburg

Registration District No. 105
Primary Registration District No. 2178
Local Registrar's No. 70
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 8 1931

2. FULL NAME J. Ward Thomas

(a) Residence. No. Rexburg St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, ~~widowed, or divorced~~
HUSBAND of ~~(or) WIFE of~~ Lauretta (Eckersell) Thomas

6. DATE OF BIRTH (month, day and year) Sept. 30, 1880

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	2	4	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Live Stock Buyer & Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9. BIRTHPLACE (city or town) Lehi
(State or country) Utah

PARENTS

10. NAME OF FATHER Joseph Thomas
11. BIRTHPLACE OF FATHER (city or town) Nauvoo
(State or Country) Illinois
12. MAIDEN NAME OF MOTHER Mary Ellen Lawrence
13. BIRTHPLACE OF MOTHER (city or town) Lima
(State or County) Illinois

14. Informant Luaretta Thomas
(Address) Rexburg Idaho

15. Filed Jan 2. 1931 J. V. Cluff Registrar

MEDICAL CERTIFICATE OF DEATH 44

16. DATE OF DEATH December 4th, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15, 1930, to Dec 4th, 1930
that I last saw him alive on Dec 2- 1930
and that death occurred, on the date stated above, at 10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma
Metastasis - lungs & liver
.....
.....(duration) .....yrs. 3 mos. .....ds.
CONTRIBUTORY (Secondary) Carcinoma of Kidney
(U.S. Hospital laboratory - Salt Lake City Utah)
.....(duration) .....yrs. 6 mos. .....ds.

18. Where was disease contracted if not at place of death? Place of death
Did an operation precede death? Yes Date of July 1930
Was there an autopsy? No
What test confirmed diagnosis? Laboratory findings

(Signed) Lorin A Beck M. D.
Dec 8 1930. (Address) Rexburg Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Rexburg	12/9 1930
20. Undertaker	Address
Reuse & Clemmer	Rexburg

Rev 7A Goltz - Salt Lake City Utah.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED JAN 16 19[illegible] STATE OF IDAHO 1-16-31

73472

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73472

PLACE OF DEATH
County of Bingham
City of Aberdeen
Registration District No. .....
Primary Registration District No. ..... Local Registrar's No. 10
(No. Residence)
(If death occurred in a hospital or institution, give its name instead of street and number.)

91 b

2. **FULL NAME** Leland D. Clinger

(a) Residence. No. Farm Aberdeen, Idaho. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Husband of Pearl Johnston Clinger

6. DATE OF BIRTH (month, day and year) January 29, 1897.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	10	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Marion Clinger

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Rebecca Dorius

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant Mrs. L. D. Clinger
(Address) Aberdeen, Idaho.

15. Filed 12/3/30, 19..... M C Martinson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 1, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Nov 30, 1930, to Dec 1, 1930
that I last saw him alive on Nov 30, 1930
and that death occurred, on the date stated above, at 12:30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Rupture of aortic aneurism.
..... (duration) do not know. yrs. mos. ds.
CONTRIBUTORY (Secondary) Fall as possibility
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) C F. Schick, M. D.
12/3/30, 19..... (Address) Am. Falls, Ida.

19. Place of Burial, Cremation, or Removal: Aberdeen Cemetery Aberdeen, Idaho. — Date of Burial: [illegible] 193

20. Undertaker: Arthur W. Hall Mortuary — Address: Pocatello

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

~~73750~~ 73477

RECEIVED FEB 4 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73477

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 1
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Eldabertha Schumacher
(a) Residence, No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Emil Schumacher
6. DATE OF BIRTH (month, day and year) May 5
7. AGE Years 61 Months 7 Days 10 If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Germany
PARENTS
10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Germany
14. Informant (Address) E. Schumacher Payette, Idaho
15. Filed Jan 7 1931 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 25 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930 to Dec 25th, 1930
that I last saw her alive on Dec 24th 1930
and that death occurred, on the date stated above, at 10 30 a.m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Intestinal obstruction
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. R. Woodward, M. D.
12/26, 1930 (Address) Payette, Idaho
19. Place of Burial, Cremation, or Removal Payette Idaho
Date of Burial Dec 28 1930
20. Undertaker Glenn C Sanders
Address Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Boville

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66

Primary Registration District No. 2148

(No. ....., ... St.)

File No. 73526

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Mae Smiley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct. 13 (Month) (Day) 1915 (Year)

7. AGE: 14 yrs. 10 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School-girl
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spokane, Wash.

10. NAME OF FATHER: Patrick Smiley

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mae Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Patrick Smiley

(Address) Boville, Idaho

15.

Filed Aug. 15 1930 E. B. Flasher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 14, 1930 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1930, to Aug 13 1930, that I last saw her alive on Aug 13 1930, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Diabetic coma

(Duration) 0 yrs. 0 mos. 2 ds.

Contributory (Secondary) Diabetis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Walter R. Werelius M. D.

19 (Address) Bovill, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida.

DATE OF BURIAL: 8/16/30 191

20. UNDERTAKER: H. R. Short

ADDRESS: Moscow

SYMS - YORK CO., PTRS. & BDRS. 19780

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73526

PLACE OF DEATH
County of Latah
City of Bovill

Registration District No. 66
Primary Registration District No. 2148
Local Registrar's No. 1
(No.) RECEIVED JAN
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret Mae Smiley

(a) Residence. No. Bovill, Ida. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 14 | Months: 10 | Days: 1 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Spokane, Wash.

PARENTS

10. NAME OF FATHER: Patrick Smiley
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Mae Thompson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Mich.

14. Informant: Patrick Smiley
(Address): Bovill, Ida.

15. Filed Aug. 15, 1930 E. B. Flasher Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 13, 1930, to Aug. 13, 1930
that I last saw her alive on Aug. 13, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Diabetis
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Walter R. Borrelius M. D.
Aug 15, 1930 (Address) Bovill, Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Moscow, Ida.	Aug. 16 1930
20. Undertaker	Address
H. R. Short	Moscow, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

74a

RECEIVED JAN 19 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73528

PLACE OF DEATH

County of Latah Registration District No. 63

City of Kendrick Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Taylor Wright

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) Sept. 16, 1837

7. AGE 93 Years | Months 3 | Days 10 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED (Retired)
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Porter Co. Indiana

PARENTS

10. NAME OF FATHER Joseph Y Wright

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn

12. MAIDEN NAME OF MOTHER Lubitha Evans

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Virginia

14. Informant (Address) Mrs Kirkendale Kendrick

15. Filed Dec 27, 1930 B. F. Nesbit Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23, 1930, to Dec 26, 1930

that I last saw him alive on Dec 26, 1930

and that death occurred, on the date stated above, at 11:30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage & resulting apoplexy & paralysis
..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Senility & arterio-sclerosis (duration) 10 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Oliver J Morehead, M. D.

Dec. 27, 1930 (Address) Kendrick, Ida

19. Place of Burial, Cremation, or Removal Kendrick | Date of Burial Dec 28 1930

20. Undertaker John J. Pickerd | Address Troy, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73529

PLACE OF DEATH
County of Latah
City of Kendrick
Registration District No. 63
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN

2. FULL NAME Richard Murphy

(a) Residence. No. St.
(If nonresident give city or town and State)
Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Murphy

6. DATE OF BIRTH (month, day and year) aug 18, 1866

7. AGE	Years	Months	Days	If LESS than 1 day,
	64	2	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Miner (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Des Moines Iowa

PARENTS

10. NAME OF FATHER unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) unknown
12. MAIDEN NAME OF MOTHER unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) unknown

14. Informant Mrs. Annie Murphy
(Address) Kendrick, Ida.

15. Filed Nov 3, 1930 B. H. Nesbit
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 1 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1930, to Nov. 1, 1930, that I last saw h[illegible] alive on Nov 1, 1930 and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) E H Field, M. D.
Nov. 1, 1930 (Address) Kendrick Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kendrick	Nov. 3 1930
20. Undertaker	Address
John J Packard	Troy, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED FEB 1931

DO NOT WRITE IN THIS SPACE
State File No. 73531

PLACE OF DEATH
County of Gem
City of Emmett
Registration District No. ____
Primary Registration District No. 6
Local Registrar's No. ____
(No. ____)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ada S. Wilfong

(a) Residence. No. ____ St. ____
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.
(If nonresident give city or town and State.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

6a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of L. R. Wilfong

6. DATE OF BIRTH (month, day and year) Oct 19 1870

7. AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
60	2	11	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer ____

9. BIRTHPLACE (city or town) Clarinda (State or country) Iowa

PARENTS

10. NAME OF FATHER Wm Spunagle
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not known
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

14. Informant (Address) Earl D. Wilfong Emmett Idaho

15. Filed Jan 2, 1931 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceas d from 12-28-, 1930, to 12-30-, 1930
that I last saw her alive on 12-30-, 1930
and that death occurred, on the date stated above, at 6 30 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Probably heart failure due to an influenzal infection & weakness from lack of food
(duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (Secondary) myocarditis
(duration) ____ yrs. ____ mos. ____ ds.

18. Where was disease contracted if not at place of death? ____
Did an operation precede death? no Date of ____
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) L. R. Cummings, M. D.
Jan 2, 1931 (Address) ____

19. Place of Burial, Cremation, or Removal: Emmett Idaho — Date of Burial: Jan 2 1931
20. Undertaker: O. Bucknum — Address: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

11b

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jefferson

City of Rigby

If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 1

Registration District No. 98

Primary Registration District No. 2176

(No. ..... St.)

File No. 73533

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Veda Packer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 10 (Day) 1930 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rigby Idaho

10. NAME OF FATHER Elmer S. Packer

11. BIRTHPLACE OF FATHER (State or Country) Soda Springs, Idaho

12. MAIDEN NAME OF MOTHER Hannah E. Crofts

13. BIRTHPLACE OF MOTHER (State or Country) Iona, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer S. Packer

(Address) Rigby, Idaho

15. Filed JAN 1 1931 19.....

C. H. GAVIN, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1930, to Dec 22 1930 that I last saw her alive on Dec. 21, 1930 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza and Bronchitis.

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. West M. D.

12/22 1930. (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby

DATE OF BURIAL: 12/23 1930

20. UNDERTAKER: none

ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

1-19-31

88b

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73534

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Melva Leonard.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 10 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Child.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6. DATE OF BIRTH (month, day and year) Mayn25,1920

7. AGE Years 10 Months 6 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS
10. NAME OF FATHER Ralph Leonard.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Mabel Elzena Williams.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Utah.

14. Informant (Address) Ralph Leonard Rigby, Idaho.

15. Filed JAN 1 1931, 19 C. H. GAVIN, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 14 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 14, 1930
that I last saw her alive on Dec 12, 1930
and that death occurred, on the date stated above, at 3:45 p.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? —
What test confirmed diagnosis?
(Signed) W. R. West, M.D.
12/16, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal Grant, Idaho. Date of Burial 12/17/30 19

20. Undertaker A B Eckersell Address Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 10 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73535

PLACE OF DEATH
County of Jefferson
City of Rigby
Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margaret [illegible] Saxton
(a) Residence. No. Rigby Side St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of wife

6. DATE OF BIRTH (month, day and year) Dec 15 1848

7. AGE 82 Years | Months 11 | Days 15 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Leeds England York Shire

PARENTS
10. NAME OF FATHER William Dearing
11. BIRTHPLACE OF FATHER (city or town) (State or Country) not known
12. MAIDEN NAME OF MOTHER not known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) not known

14. Informant (Address) Thomas Saxton

15. Filed JAN 1 1931, 19 C. H. GAVIN, M.D. RIGBY, IDAHO Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15, 1930, to Nov 28, 1930
that I last saw her alive on Nov 22, 1930
and that death occurred, on the date stated above, at 6 30 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chr. Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) C. H. Gavin, M. D.
11-29, 1930 (Address) Rigby

19. Place of Burial, Cremation, or Removal Rigby | Date of Burial Dec 2, 1930

20. Undertaker Vern Kelker | Address Rexburg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED JAN [illegible] 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 98

DO NOT WRITE IN THIS SPACE
State File No. 73536

PLACE OF DEATH
County of Jefferson
City of Rigby
Registration District No. 2176
Primary Registration District No. [illegible] Local Registrar's No. [illegible]
(No. [illegible])
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Elizabeth Ellen Jones.

(a) Residence. No. [illegible] St. [illegible]
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 45 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Widowed

5a. If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of John F. Jones.

6. DATE OF BIRTH (month, day and year) Aug. 8, 1855

7. AGE	Years	Months	Days	If LESS than 1 day, [illegible] hrs. or [illegible] min.
	75	4	20	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) U. S. A.

PARENTS

10. NAME OF FATHER William Jones.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Ann Haddock.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Wales.

14. Informant (Address) Celia Jones Rigby. R. #2

15. Filed JAN 1 1931 C. H. GAVIN. M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 28 1930, 19[illegible]
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28, 1930, to Dec 28, 1930, that I last saw h[illegible] alive on Dec 28, 1930 and that death occurred, on the date stated above, at 7 p. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Myocardial Con
(duration) [illegible] yrs. [illegible] mos. [illegible] ds.
CONTRIBUTORY (Secondary) Senility
(duration) [illegible] yrs. [illegible] mos. [illegible] ds.

18. Where was disease contracted if not at place of death? [illegible]
Did an operation precede death? No Date of [illegible]
Was there an autopsy? No
What test confirmed diagnosis? [illegible]
(Signed) [illegible] M. D.
12 30, 1930 (Address) Rigby

19. Place of Burial, Cremation, or Removal: Rigby, Idaho. Date of Burial: 12/23/30

20. Undertaker [illegible] Address: Rigby

90

RECEIVED JAN 19 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73537

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louisa Clegg.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 33 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Widowed.

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of William Clegg

6. DATE OF BIRTH (month, day and year) Aug. 1, 1847

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	23	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) England

PARENTS

10. NAME OF FATHER James Giddins

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Hadley

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Lyman Clegg Rigby Idaho

15. Filed JAN 1 1931, 19 C. H. GAVIN, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 24 1930, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
, 19 , to , 19
that I last saw her alive on Dead 11/26, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Probable Heart Attack, from General Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old Age
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis?
(Signed) Ira J. Taylor Coroner M. D.
19 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Shelton, Idaho.
Date of Burial: 11/29/3 19

20. Undertaker: A B Edwards
Address: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 1 0 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73538

PLACE OF DEATH

County of ~~Bonneville~~ Jefferson

City of Rigby R.F.D. 1

CERTIFICATE OF DEATH 98

Registration District No. .....

Primary Registration District No. 2.76 . Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Lyle Dean Crystal

(a) Residence. No. Rigby R.F.D. 1 St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Infant

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) Dec 10, 1930

7. AGE

Years	Months	Days	If LESS than 1 day,
0	0	9	12 hrs. or 55 min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer ✓

9. BIRTHPLACE (city or town) (State or country) Bonneville County Rigby R.F.D. 1

PARENTS

10. NAME OF FATHER Andrew Vernon Crystal

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Salt Lake City Ut.

12. MAIDEN NAME OF MOTHER Bessie V. Randall

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Grant Ida.

14. Informant (Address) D R Crystal Rigby R.#1

15. Filed JAN 1 1931 19..

C. H. GAVIN, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 20 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 20, 1930

that I last saw him alive on Dec 20, 1930

and that death occurred, on the date stated above, at 7:00 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) None.

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. R. Abbott M. D.

Dec 20, 1930 (Address) Ririe Ida.

19. Place of Burial, Cremation, or Removal: Grant Ida. Date of Burial: 12-21 1930

20. Undertaker: A B Eckwall Address: Rigby

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 48

RECEIVED JAN [illegible] 1931

DO NOT WRITE IN THIS SPACE
State File No. 73539

PLACE OF DEATH
County of Jefferson
City of Menan

Registration District No. 48
Primary Registration District No. 2176
Local Registrar's No.
(No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Delina Merrill

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word.)
Female	W.	

5a. If married, widowed, or divorced
HUSBAND
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 10th 1930

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	28.	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Menan
(State or country) Ida.

PARENTS

10. NAME OF FATHER Laurence Merrill
11. BIRTHPLACE OF FATHER (city or town) Independence
(State or Country) Ida.
12. MAIDEN NAME OF MOTHER Annie May Hall
13. BIRTHPLACE OF MOTHER (city or town)
(State or County) Menan Ida.

14. Informant Laurence Merrill
(Address) Box Lorenzo Ida R 1

15. Filed , 19
C. H. GAVIN M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 8, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceas d from
Dec. 7, 1930, to Dec 8, 1930
that I last saw her alive on Dec. 8, 1930
and that death occurred, on the date stated above, at 4:10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? NO Date of
Was there an autopsy? NO
What test confirmed diagnosis? NO
(Signed) C. H. Gullickland, M. D
12-10, 1930 (Address) Rexburg, Ida

19. Place of Burial, Cremation, or Removal: Cedar Butte — Date of Burial: Dec. 10 1930
20. Undertaker: Dyer & Kellen Address: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

101a

DO NOT WRITE IN THIS SPACE
State File No. 73540

RECEIVED JAN 9 1931

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176

Local Registrar's No.

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David White.

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of ~~XXXXXX~~ Bertha White.

6. DATE OF BIRTH (month, day and year) Feb. 14 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	54	3	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9. BIRTHPLACE (city or town) (State or country) Utah.

PARENTS

10. NAME OF FATHER Wm. Merion White.

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Martha Ann Gray.

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ga.

14. Informant Bertha White
(Address) Rigby, R. #3

15. Filed JAN 1 1931 C. H. GAVIN M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th, 1930, to June 5th, 1930
that I last saw her alive on June 5 1930
and that death occurred, on the date stated above, at 6 A. m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of ✓
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H. A. Anderson, M. D.
June 6, 1930 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Idaho Falls, Idaho.	6/ 19

20. Undertaker	Address
B Eckersell	Rigby

101a

RECEIVED JAN 1 9 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73541

98
176

PLACE OF DEATH
County of Jefferson
City of Bybee.
Registration District No.
Primary Registration District No.
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Virginia Goody

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F. M.	White	Babe

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Babe

6. DATE OF BIRTH (month, day and year) November 22 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Babe
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Bybee, Idaho.

PARENTS

10. NAME OF FATHER Edwin Leroy Goody
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lewisville, Idaho.
12. MAIDEN NAME OF MOTHER Nina Virginia Fredrickson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho.

14. Edwin Leroy Goody.
Informant
(Address) Lewisville, Idaho.

15. Filed JAN 1 1931
C. H. GAVIN, M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 14-30, 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
On Dec 13th, 1930, to , 19
that I last saw her alive on Dec 1st, 1930
and that death occurred, on the date stated above, at 7.30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) unknown
(duration) yrs. mos. ds.

18. Where was disease contracted, if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) D. A. Anderson, M. D
Dec 15 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal: Lewisville, Idaho. Date of Burial: 12/16/30 19

20. Undertaker Address Rigby

RECEIVED JAN [illegible] 193[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73542

PLACE OF DEATH
County of Jefferson
City of Roberts

Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No. .....
(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Carl Jorgy

(a) Residence. No. ..... Roberts, Idaho St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Katherine Jorgy

6. DATE OF BIRTH (month, day and year) January 28, 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10. NAME OF FATHER Peter Jorgy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not known
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant (Address) Chas Jorgy Roberts, Idaho

15. Filed JAN 1 1931 19..... C. H. GAVIN, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 5 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 19..... to Dec 3rd, 19.....
that I last saw him alive on Dec 3rd, 19.....
and that death occurred, on the date stated above, at 8:50 a. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bad [illegible] but
did not treat him
as he was then
Began 9/1 (duration) yrs. mos. ds.
CONTRIBUTORY old age only
(Secondary)
[illegible] (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) R. D. Lucky M. D.
Dec 6, 1930 (Address) Idaho Falls, Idaho

19. Place of Burial, Cremation, or Removal Murray, Utah — Date of Burial Dec 8 1930

20. Undertaker Jack A. Wood — Address Idaho Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

101a

RECEIVED JAN 19 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73543

PLACE OF DEATH
County of Jefferson
City of Rigby

Registration District No. 98
Primary Registration District No. 2176 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Treena Hoffman
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Widow

5a. If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept 25-1867

7. AGE 63 Years 3 Months Days If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Denmark

PARENTS
10. NAME OF FATHER Christian Peterson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Charles Densdale Lorenzo Ida. #1

15. Filed JAN 1 1931 JAN 1 1931 G. H. GAVIN, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH 101a

16. DATE OF DEATH Dec. (Month) 25th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1930, to Dec 24, 1930
that I last saw her alive on Dec 24, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) W. R. West M. D.
12/25, 1930 (Address) Rigby Idaho

19. Place of Burial, Cremation, or Removal Lewisville Ida. Date of Burial Dec. 27 1930

20. Undertaker Vern J. Keller Address Rexburg

MARGIN RESERVED FOR BINDING.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

VITAL JAN 16 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73544

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 40
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

71

2. FULL NAME Darrel Ernest Haugen

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wh.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9. BIRTHPLACE (city or town) Spirit Lake
(State or country) Ida

PARENTS

10. NAME OF FATHER Edward R. Haugen

11. BIRTHPLACE OF FATHER (city or town)
(State or Country) N. Dak

12. MAIDEN NAME OF MOTHER Ida Brown

13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) N. Dak

14. Informant Edward R. Haugen
(Address) Spirit Lake Ida

15. Filed Nov 4, 1930 A. C. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24, 1930, to Nov 4, 1930
that I last saw him alive on Nov 4, 1930
and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:
Meningitis (not epidemic)
Probably pneumococcic
extension from ear
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suppurative otitis media
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Spinal puncture

(Signed) A. C. Spooner, M. D.
Nov 4, 1930 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Spirit Lake Ida	Nov 5 1930

20. Undertaker	Address
Cassedy Funeral Home	Rathdrum Ida

88 K

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73545

PLACE OF DEATH
County of Kootenai
City of Harrison

Registration District No. 126
Primary Registration District No. 2304
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. .....

2. FULL NAME Wm Walker

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word) single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) About 1864

7. AGE Years 66 Months Dont Know Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Dont Know. no relatives here.

9. BIRTHPLACE (city or town) (State or country)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (city or town) (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Connelly Hospital
(Address) Harrison

15. Filed Dec 8, 1930 H W Shryock Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 6 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1930, to Dec 6, 1930
that I last saw him alive on Dec. 6, 1930
and that death occurred, on the date stated above, at 8:30 P m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) ..... yrs. ..... mos. 8-10 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) H W Shryock, M. D.
Dec 8, 1930 (Address) Harrison

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Harrison Ida
Date of Burial 12-8 1930

20. Undertaker Cassedy Funeral Home
Address Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECD JAN 16 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73546

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 4 S
Primary Registration District No.
Local Registrar's No. 5

(No. 87)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Donald McPhail

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wh.	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edna McPhail

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	45	2	7	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Transfer man + Fuel
(b) General nature of industry, business, or establishment in which employed (or employer) dealer
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Saratoga Wyo

PARENTS

10. NAME OF FATHER Donald McPhail
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland
12. MAIDEN NAME OF MOTHER Do not know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) England

14. Informant Edna McPhail
(Address) Spirit Lake Ida

15. Filed Dec 10, 1930 I C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 9 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Dec 9 , 1930
that I last saw h~~im~~ alive on Dec 9 , 1930
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Angina pectoris
one hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) I C Spooner, M. D.
Dec 10, 1930 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery Spirit Lake Ida	Dec 14 1930

20. Undertaker Conedy Funeral Home
Address Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

43-a

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73547

Registration District No. 45
Primary Registration District No.
Local Registrar's No. 3

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Louise Dorthea Feise

(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F.	Wh.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Feise

6. DATE OF BIRTH (month, day and year) Oct 24 - 1907

7. AGE	Years	Months	Days	If LESS than 1 day,
	23	0	9	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Carlin Bay Idaho

PARENTS

10. NAME OF FATHER Herman Neubauer
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12. MAIDEN NAME OF MOTHER Mathilda Kruger
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14. Informant Arthur Feise
(Address) Spirit Lake, Ida

15. Filed Nov 5, 1930 C. C. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 4 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29, 1930, to Nov 4, 1930
that I last saw her alive on Nov 4, 1930
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:
Peritonitis following abortion and scarlet-fever
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W. Schaer, M. D.
Nov 5, 1930 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal — Greenwood Cemetary Spirit Lake Ida — Date of Burial 11-5- 1930

20. Undertaker Cassady Funeral Home — Address Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 1 8 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1-1631

129

DO NOT WRITE IN THIS SPACE
State File No. 73548

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
(No. Spirit Lake Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Francis Dadie Dolan

(a) Residence. No. Spirit Lake Ida St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Aug 23 1922

7. AGE — Years: 8 | Months: 0 | Days: 29 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School-boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lepanto Colo

PARENTS

10. NAME OF FATHER Dadie Dolan
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Texas
12. MAIDEN NAME OF MOTHER Cora Ford
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Okla

14. Informant Ray Dolan
(Address) Spirit Lake Ida

15. Filed Sept 23, 1930 A. A. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930 to Sept 21, 1930
that I last saw him alive on Sept 20, 1930
and that death occurred, on the date stated above, at 1.50 A. m.

The CAUSE OF DEATH* was as follows:
Shock from 3rd degree burns acc. explosion of gasoline blow-torch.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) John W Schaeri, M. D.
9-21 1930 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Greenwood Cem - Spirit Lake Ida — Date of Burial: 9-23 1930

20. Undertaker: Cassedy Funeral Home — Address: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED JAN 16 1931

179

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73549

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
(No. Spirit Lake Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Elvin C. Call

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wh.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day,
	8	2	29	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work School-boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Spirit Lake, Ida

PARENTS

10. NAME OF FATHER Alva C Call

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Camilla Donovan

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Iowa

14. Informant Mrs Camilla Call
(Address) Spirit Lake Ida

15. Filed Sept 22, 1930 W C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 21 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20, 1930, to Sept 21, 1930
that I last saw him alive on Sept 21, 1930
and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:
Shock following extensive 3rd degree burns from acc. explosion of gasoline blow-torch,
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) John W Sahara, M. D.
Sept 22 1930 (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairmont Cemetary Spokane Wash	9-23 1930

20. Undertaker	Address
Cassedy Funeral Home	Rathdrum Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Corrected Certificate

129

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73562

PLACE OF DEATH
County of Bannock
City of Pocatello

RECEIVED JAN 1[illegible]

Registration District No. 28
Primary Registration District No. 2161
(No. 527 S. Harrison)
(If death [illegible] in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 5898

2. FULL NAME Mr. C. Giordano
(a) Residence. No. 5[illegible] S. Harrison St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town [illegible]h occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL A[illegible]L PARTICULARS

3. SEX Female
4. COL[illegible] Wh[illegible]
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Giordano

6. DATE OF BIRTH (month, day and year) Nov 7 - 1870

7. AGE Years 59 Months 10 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Italy

PARENTS
10. NAME OF FATHER Joseph Puelo
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Italy
12. MAIDEN NAME OF MOTHER Di Girolamo Judaco Francesca
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Bivong Italy

14. Informant Sam Giordano
[illegible] Idaho

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 10 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1930, to Sept 10, 1930
that I last saw her alive on Sept 10, 1930
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(duration) Few yrs. — mos. — ds.
CONTRIBUTORY (Secondary) Uremia
(duration) ..... yrs. ..... mos. 5 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) William F. Howard M. D.
9/11, 1930 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Mountain View
Date of Burial Sept 14 1930

20. Undertaker Schumacher & Beasley Inc
Address Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA[illegible] [illegible]ery important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73566

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Margurett Salena Morrison
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Morrison

6. DATE OF BIRTH (month, day and year) Sept 22 1856

7. AGE Years 74 Months 3 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House work at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ogden Utah

PARENTS
10. NAME OF FATHER Joseph Perkins
11. BIRTHPLACE OF FATHER (city or town) (State or Country) South Wales
12. MAIDEN NAME OF MOTHER Margurett Mortin
13. BIRTHPLACE OF MOTHER (city or town) (State or County) South Wales

14. Informant (Address) J.E.Morrison Jerome Idaho

15. Filed 12/25, 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 22, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12, 1928, to Dec 22, 1930
that I last saw her alive on Dec 20, 1930
and that death occurred, on the date stated above, at 6 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
General arteriosclerosis
Chronic Brights
Disease - Uremia
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) [signature], M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal Franklin Idaho
Date of Burial Dec. 26 1930

20. Undertaker M. W. Hendricks
Address Preston Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PHYSICIAN

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED FEB 6 193[illegible]

DO NOT WRITE IN THIS SPACE

State File No. 73567

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Franklin

City of Preston RD 3

Registration District No. 27

Primary Registration District No. 2119

Local Registrar's No. 4

(No. .....)

(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Verlene Ingler

(a) Residence. No. RFD - 3 St. Preston Idaho
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	white	Single

5a. If married, widowed, or divorced
HUSBAND of —
(or) WIFE of —

6. DATE OF BIRTH (month, day and year) July 9-1930

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	12	—

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9. BIRTHPLACE (city or town) Preston Idaho
(State or country)

PARENTS

10. NAME OF FATHER Melvin Ingler

11. BIRTHPLACE OF FATHER (city or town) Fairview, Idaho.
(State or Country)

12. MAIDEN NAME OF MOTHER Zelda Lewis

13. BIRTHPLACE OF MOTHER (city or town) Smithfield Ut
(State or County)

14. Informant Mrs Jos Ingler
(Address) R-D 3 Preston Ida

15. Filed 1-19-, 1931 A. R. Crabb Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec - 21 - 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21-, 1930, to Dec 21-, 1930
that I last saw her alive on Dec 21, 1930
and that death occurred, on the date stated above, at 3 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) G. W Stokes, M. D.
Dec 22, 1930. (Address) Preston Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Fairview, Idaho.	12/23 1930
20. Undertaker	Address

RECEIVED JAN 16 1931

89

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73573

PLACE OF DEATH
County of Bingham
City of Aberdeen

Registration District No.
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 11

2. FULL NAME Andrew Hansen

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Susan H.

6. DATE OF BIRTH (month, day and year) 1850 - June 3.

7. AGE Years 80 Months 6 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Iowa

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark
12. MAIDEN NAME OF MOTHER Not Known.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark

14. Informant Andy Hansen Jr.
(Address)

15. Filed 12/24, 1930 McMorkinnon Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dead suddenly before that I last saw him alive on Dr was called and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Had number of previous attacks
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) C. F. Schiefer, M. D.
12/24, 1930 (Address) Am. Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Aberdeen Ida
Date of Burial 12-26 1930

20. Undertaker A W Davis
Address Am Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Ft.Hall Jurisdiction . Current complete

Nov. 1930 FEB 7 193

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73575

PLACE OF DEATH

County of Bingham.

City of Ft.Hall Reservation

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 1.

(No. At Ranch.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Christine Lewis.

(a) Residence. No. --- St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Bannock Ind.4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: -----

6. DATE OF BIRTH (month, day and year): Apr. 5, 1929

7. AGE: Years 1 | Months 7 | Days 2 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Ft.Hall Reservation.

PARENTS

10. NAME OF FATHER: Dick Lewis

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ft.Hall Reservation

12. MAIDEN NAME OF MOTHER: Jeanette James

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft.Hall Reservation

14. Informant: Homer lewis.
(Address): Ft.Hall,Idaho.

15. Filed Feb.1, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH 32

16. DATE OF DEATH: Nov.7, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Nov.1, 1930, to Nov.7,1930 19
that I last saw her alive on Nov.6, 1930, 19
and that death occurred, on the date stated above, at 5: P. m.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis,-cerebral.

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) ---

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? **

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [signature] M. D.

--, 19 (Address) Ft.Hall,Ida 3/4

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Butte Cemetery Ft.Hall Reservation, II-10-30. | Date of Burial 19

20. Undertaker: Homer Lewis, | Address: Ft.Hall, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Ft.Hall Jurisdiction. Current Complete Nov. 1930 RECEIVED FEB 7 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73576

PLACE OF DEATH

County of Bingham

City of Ft.Hall Reservation

Registration District No. 121

Primary Registration District No. 2194

Local Registrar's No. 4

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elaine Pandoah

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind.4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ---

6. DATE OF BIRTH (month, day and year): Dec. 8, 1929

7. AGE: Years | Months: II | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9. BIRTHPLACE (city or town) (State or country): Ft.Hall Res.

PARENTS

10. NAME OF FATHER: Michael Pandoah

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Susan Taquaynah

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ft.Hall Res.

14. Informant: Michael Pandoah.
(Address): Ft.Hall,Idaho

15. Filed Feb. 1, 1931 Mrs Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 15, 1930 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr. F.W.Mitchell, 19 ..., 19 ..., Blackfoot, Idaho. that I last saw him alive on ..., 19 ..., and that death occurred, on the date stated above, at 7: P m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis,- cerebral

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) --

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Phys. Signs

(Signed) Henry R. Wheeler M. D.

....., 19 ..... (Address) Ft.Hall,Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Presbyterian Mission, Ft.Hall, Res. | Date of Burial: 11/18/30 19

20. Undertaker: Brown-Eldredge, Blackfoot, Ida. | Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

Current Complete

November 1931

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73578

Ft. Hall Jursidiction

PLACE OF DEATH

County of Bingham

City of Ft. Hall Reserv.n

Registration District No. I2I

Primary Registration District No. 2I94

Local Registrar's No. 5

(No. No Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ruth George

(a) Residence. No. ---- St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word.): Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: General George

6. DATE OF BIRTH (month, day and year): I874

7. AGE: Years 56; Months --; Days --; If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Own Home

9. BIRTHPLACE (city or town) (State or country): Glenns Ferry, Idaho

PARENTS

10. NAME OF FATHER: Joe Jackson

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Glenns Ferry, Idaho

12. MAIDEN NAME OF MOTHER: Wizatah.

13. BIRTHPLACE OF MOTHER (city or town) (State or County): Glenns Ferry, Idaho

14. Informant (Address): Minnie Littlejohn, Blackfoot, Idaho

15. Filed Feb. I, 1931. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. I5, I930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr. Lynn, Pocatello, Idaho. 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 5:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Cancer of neck & Jaw.

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Excision, cancer

(duration) ... yrs. ... mos. 13 ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) [signature], M. D.

..., 19... (Address) Ft. Hall, Ida

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Presbyterian Mission, Ft. Hall Reservation, Idaho

Date of Burial: II/I9/30 19

20. Undertaker: Brown & Eldredge, Blackfoot, Idaho

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73585

PLACE OF DEATH
County of Bingham
City of Shelley

Registration District No. 121
Primary Registration District No. 2194
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Arsene Hall
(a) Residence. No. Shelley Ida St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Babe

6. DATE OF BIRTH (month, day and year)

7. AGE 1 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work baby
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Joseph Utah

PARENTS
10. NAME OF FATHER Harry Hall
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Beaver Utah
12. MAIDEN NAME OF MOTHER Eva Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Joseph Utah

14. Informant Harry Hall
(Address) Shelley Ida

15. Filed Jan 31, 1931 Mrs Helen E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-29, 1930, to 12-30, 1930
that I last saw him alive on 12-29-, 1930
and that death occurred, on the date stated above, at 2:30 P.m.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(duration) yrs. mos. 5 ds.
CONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. 3 mos. ds.

18. Where was disease contracted if not at place of death? At home
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Edwin Custer, M. D.
1-2-, 1931 (Address) Shelley Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation,~~ or ~~Removal~~ Shelley Ida | Date of Burial 1-2 1938

20. Undertaker (Acting) Harry Hall | Address Shelley Idaho

Ft.Hall Jurisdiction. Current Complete Nov.22, 1930

RECEIVED FEB 7 19

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73587

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Bingham Registration District No. 121

City of Ft.Hall Reser'vn. Primary Registration District No. 2194 Local Registrar's No. 6

(No. Ft.Hall Agency Hospital.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elaine Phelps

(a) Residence. No. ---- St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Shoshone Ind.4/4

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6. DATE OF BIRTH (month, day and year) Oct.4, 1930

7. AGE Years Months I Days 18 If LESS than 1 day, ...hrs. or ...min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall,Idaho.

PARENTS

10. NAME OF FATHER Johnnie Phelps

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ft.Hall Reservation

12. MAIDEN NAME OF MOTHER Mollie Dunn

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant (Address) Mollie Phelps Ft.Hall,Idaho.

15. Filed Feb.1, 1931 Mrs Helen E. Catlett Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 22, 1930 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1930 to Nov.22, 1930, 19

that I last saw her alive on Nov. 22, 1930, 19

and that death occurred, on the date stated above, at 11:30P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Flu & Pneumonia,-bronchial

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phus. Signs

(Signed) [signature], M. D.

19 (Address) Ft.Hall,Ida

19. Place of Burial, ~~Cremation~~, or ~~Removal~~ Episcopal Mission, Ft.Hall Reservation, Date of Burial 11/24/30 19

20. Undertaker Agency Carpenter, Ft.Hall, Idaho. Address

should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

Current Complete

Nov. 1930

Ft. Hall Jurisdiction.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED FEB 7 1931

DO NOT WRITE IN THIS SPACE
State File No. 73594

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 1007

Local Registrar's No. 3

(No. In Auto on Main Street 200 Block)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elmore Wettembonne.

(a) Residence. No. Ft. Hall Reservation. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6. DATE OF BIRTH (month, day and year) 1904

7. AGE	Years	Months	Days	If LESS than 1 day,
	26	--	--	hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Own farm

9. BIRTHPLACE (city or town) (State or country) Lemhi Reservation

PARENTS

10. NAME OF FATHER Wettembonne

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Jennie Turnembucco

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Lemhi Reservation

14. Informant Jennie Wettembonne.

(Address) Ft. Hall, Idaho

15. Filed Feb. I, 1931 Wm Valentine Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. I3, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No doctor attending., 19..
that I last saw h... alive on ..., 19..
and that death occurred, on the date stated above, at 4: A. m.

The CAUSE OF DEATH* was as follows:

Poisoned from drinking wood alcohol,- unintentional.

(duration) ... yrs. ... mos. I ds.

CONTRIBUTORY (Secondary) Tuberculosis-pulmonary.

(duration) 4 yrs. ... mos. ... ds.

18. Where was disease contracted if not at place of death? Blackfoot, Ida.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) Henry R. Wheeler M. D.

-- , 19.. (Address) Ft. Hall, Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~	Date of Burial
Butte Cemetery, Ft. Hall Reservation, Id	I/I9/30 19

20. Undertaker Brown-Eldredge, Blackfoot, Ida — Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Ft. Hall Jurisdiction.

Current Complete November 1930 FEB 7 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73595

PLACE OF DEATH

County of Bingham

City of Blackfoot

Registration District No. I2I

Primary Registration District No. ~~XIXX~~ I007

Local Registrar's No. 2

(No. County Jail.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Geyser Yellowstone.

(a) Residence. No. Ft. Hall Reservation St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of --------

6. DATE OF BIRTH (month, day and year) I9I3

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
I7	--	--	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Gov. School pupil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Lemhi Reservation

PARENTS

10. NAME OF FATHER: Henry Yellowstone

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Lemhi Reservation

12. MAIDEN NAME OF MOTHER: Louise Squirrel

13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Lemhi Reservation

14. Informant: Louise Yellowstone.

(Address) Ft. Hall, Idaho.

15. Filed Feb. I, 19 3I Wm Walter E. Patrick Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. I3, I930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Treated by Dr. J. O. Hampton, Blackfoot, Idaho. to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at I;45 P m.

The CAUSE OF DEATH* was as follows:

Poisoned by drinking wood alcohol- unintentional.

(duration) yrs. 6 hrs ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis.

(duration) I yrs. 2 mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot, Idaho

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) Henry R. Wheeler M. D.

, 19 (Address) Ft. Hall, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Butte Cemetery, Ft. Hall Reservation, II

Date of Burial: I9/30 19

20. Undertaker: Modern Mortuary, Blackfoot, Idaho.

Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO 167
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

County of Owyhee

City of Silver City

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 43

Primary Registration District No. 2120

(No. ..... St.)

State File No. 73614 3

Local Registrar's No. .....

2. FULL NAME Mrs Willimena Grete

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1843 (Year)

7. AGE: 87 Yrs. 2 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF Father: Jacob Koenman

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: don't Know

13. BIRTHPLACE OF MOTHER (State or Country): don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. F. Grete

(Address) Silver City Idaho

15. Filed Oct. 20th. 1930 R. H. Leonard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19...., to ..... 19...., that I last saw h..... alive on ..... 19...., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Died of Old age.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Grete ~~M. D.~~

10-20, 1930 (Address) Silver City Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Silver City, Idaho

DATE OF BURIAL: Oct 9th 1930

20. UNDERTAKER: John Grete

ADDRESS: Silver City, Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 1 1931

154

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73615

PLACE OF DEATH
County of Bonneville
City of Idaho Falls.

Registration District No. 78
Primary Registration District No. 2176
(No. Idaho Falls L. D. S. Hosp.)
Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Edna Birtie Loynd

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 2 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single.

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Sept. 11, 1915

7. AGE Years 15 Months 2 Days 1 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho.

PARENTS

10. NAME OF FATHER John Loynd
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Utah.
12. MAIDEN NAME OF MOTHER Birtie Leona McMurtrey
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Alabama.

14. Informant (Address) John Loynd. Rigby, Idaho. R. #3

15. Filed JAN 1 1931 19 C. H. GAVIN, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 12 1930 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1930, to Dec 12, 1930
that I last saw her alive on Dec 12, 1930
and that death occurred, on the date stated above, at m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Streptococcic cellulitis of lower lip chin & neck.
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) furuncle lip.
(duration) yrs. mos. 9 ds.

18. Where was disease contracted if not at place of death? Ririe, Idaho
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory
(Signed) H Ray Patch, M. D.
Dec 12, 1930 (Address) Idaho Falls

19. Place of Burial, Cremation, or Removal Rigby, Idaho. Date of Burial 12/15/30 19

20. Undertaker A B Eckersell Address Rigby

FORM V. S. No. 5-A—25 M. 1-19.

1612

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 73616
Registered No.

1. PLACE OF DEATH
County of Bonneville
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED JAN 5 1931

2. FULL NAME Premature

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Nov. 21 (Month) 1930 (Day) (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant Premature
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jefferson

10. NAME OF FATHER: Lars Hanson

11. BIRTHPLACE OF FATHER (State or Country): Spanish Fork Utah

12. MAIDEN NAME OF MOTHER: Ethel Button

13. BIRTHPLACE OF MOTHER (State or Country): Lyman Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Father
(Address): Rigby

15.
Filed JAN 1 1931 19.... C. H. GAVIN, M.D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 21 (Month) (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1930, to Nov. 21, 1930
that I last saw h..... alive on.....19.....
and that death occurred on the date stated above, at.....M.
The CAUSE OF DEATH* was as follows:

Premature, born 15 minutes

.....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

.....(Duration) ....yrs....mos....ds.

(Signed) W. R. West M. D.
11/22 19 30 (Address) Rigby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Home | DATE OF BURIAL: 10-21-30 19....

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 16 1931

DO NOT WRITE IN THIS SPACE
State File No. 73629

PLACE OF DEATH

County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 2150
(No. L. C. S. Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. ✓

159 e

2. FULL NAME Eva Tavern Palmer
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year): December 23, 1930

7. AGE: Years | Months | Days 7 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Idaho Falls, Idaho

PARENTS

10. NAME OF FATHER: Alden E. Palmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Mountain Home, Utah
12. MAIDEN NAME OF MOTHER: Irene Noe
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Salt Lake, Utah

14. Informant: B. F. Noe
(Address): Idaho Falls, Idaho

15. Filed Jan 3, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 30 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23, 1930, to Dec 31, 1930
that I last saw her alive on Dec. 31, 1930
and that death occurred, on the date stated above, at 12-30 P m.
The CAUSE OF DEATH* was as follows:
Congenital Esophageal Stenosis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? yes. Date of Dec 26-30
Was there an autopsy? no
What test confirmed diagnosis? ✓
(Signed) A. R. Sodenquist, M. D.
Jan 3, 1931 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Idaho Falls, Idaho | Date of Burial: Jan 2 1930

20. Undertaker: Jack A. Wood | Address: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 1 1931

DO NOT WRITE IN THIS SPACE
State File No. 73631

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 23
Primary Registration District No. 2140
Local Registrar's No. 4
(No.) L. D. S. Hospital 189
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lester Steffensen
(a) Residence. No. [illegible] St. Blackfoot, Ida.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Oct. 12 1912

7. AGE	Years	Months	Days	If LESS than 1 day,
	18	2	18	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Blackfoot Ida.

PARENTS

10. NAME OF FATHER Jesse Steffensen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mink Creek Ida.
12. MAIDEN NAME OF MOTHER Marie Pukkendal
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Denmark.

14. Informant Jesse Steffensen
(Address) 11 Blackfoot, Ida

15. Filed Jan 8, 1931 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26, 1930, to Dec 29, 1930
that I last saw h[illegible] alive on Dec 29, 1930
and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:
Traumatic Pancreatitis, Fat necrosis
(duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Kicked in belly by a horse 3 days before
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Blackfoot.
Did an operation precede death? Yes Date of Dec 29, 1930
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) H. Ray Hatch M. D.
Dec 30, 1930 (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Blackfoot Ida.	Dec. 31 1930

20. Undertaker	Address
Jack A. Wood	Idaho Falls

RECEIVED FEB 16 1931

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73632

PLACE OF DEATH
County of Bonneville
City of Idaho Falls

Registration District No. 73
Primary Registration District No. 214-8
Local Registrar's No. 3

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Orvil Dennis 185'
(a) Residence. No. Idaho Falls, Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Dennis

6. DATE OF BIRTH (month, day and year) July 13, 1887

7. AGE Years 43 Months 5 Days 17 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) /
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Nebraska

PARENTS
10. NAME OF FATHER Burr Dennis
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Crouch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs. Edith Dennis
(Address) Idaho Falls, Idaho

15. Filed Jan 3, 1931 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at 4-30 p m.
The CAUSE OF DEATH* was as follows:
Accidental
6 ton steele Beam falling
& crushing skull & chest
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) Dr. B. J. Allen M. D.
Dec. 31, 1930 (Address) Coroner Idaho Falls, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Idaho Falls, Idaho
Date of Burial Jan 2 1931

20. Undertaker Carl A. Nord
Address Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73664

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Custer
City of Challis

Registration District No. 108
Primary Registration District No. 2186 Local Registrar's No. 112
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Mrs. Sarah Bradbury Peck
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Leonard Peck

6. DATE OF BIRTH (month, day and year): March 24. 1865

7. AGE: Years 75, Months 9, Days 2. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): Willard Utah

PARENTS

10. NAME OF FATHER: William Bradbury
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Carventry England
12. MAIDEN NAME OF MOTHER: Jane Dunston
13. BIRTHPLACE OF MOTHER (city or town) (State or County): England

14. Informant (Address): Julia McGowan Challis, Ida.

15. Filed Dec 28, 1930 Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

No doctor in attendance

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) ....., M. D.
....., 19..... (Address) Challis, Idaho

19. Place of Burial, Cremation, or Removal: Challis, Idaho — Date of Burial: Dec. 28 1930

20. Undertaker: Bert Mecham — Address: Arco, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73701

PLACE OF DEATH
County of Ada
City of Kuna

Registration District No.
Primary Registration District No.
(No.) Local Registrar's No.
(If death occurred in a hospital or institution, give its name instead of street and number.)

RECEIVED JAN 19

2. FULL NAME Mary Cora Fields
(a) Residence. No. St. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred. 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of George S. Fields

6. DATE OF BIRTH (month, day and year) Dec 6-1880

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	24	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) St Johns Missouri

PARENTS

10. NAME OF FATHER Garrett Scott
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Westchester Penn.
12. MAIDEN NAME OF MOTHER Ann Jane Reece
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Indiana

14. Informant
(Address)

15. Filed 12-30, 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-24, 1930, to 9-30, 1930, that I last saw her alive on 9-26, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:
Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Brights disease
(duration) 3 yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Original

(Signed) R. A. Neal, M. D.
9/30, 1930 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Kuna	10-2 1930
20. Undertaker	Address
Wm McBratney	Boise

FORM V. S. No. 5-A-25M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 73702

Local Registrar's No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Valley

City of McCall, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

2. FULL NAME Harriet Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Widowed

6. DATE OF BIRTH

4th (Month) Ist (Day) 1839 (Year)

7. AGE

91 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kentucky ~~Georgia~~

10. NAME OF Father Mr— Henry

11. BIRTHPLACE OF FATHER (State or Country) —*

12. MAIDEN NAME OF MOTHER *

13. BIRTHPLACE OF MOTHER (State or Country) *

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Shaw

(Address) McCall Ida

15.

Filed ..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

10th (Month) 8th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1926 19..., to Oct. 8th, 1930 19..., that I last saw her alive on Oct. 8th, 1930 19..., and that death occurred on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:

Arterio- Sclerosis

(Duration) 4 yrs. mos. ds.

Contributory (Secondary) Cardiac Insufficiency.

(Duration) 0 yrs. 7 mos. ds.

(Signed) Dr. U. S. Peratt M. D.

10-8 1930 (Address) McCall, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL McCall Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER W. D. Pott

ADDRESS

112

RECEIVED JAN 26 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73724

PLACE OF DEATH
County of Gooding
City of Wendell

Registration District No. 22
Primary Registration District No. 2018
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

1-26-3

2. FULL NAME Cholian Monroe Weinberg

(a) Residence. No. ..... St. ✓
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nadia Wemberg

6. DATE OF BIRTH (month, day and year) Sept 19 1861

7. AGE	Years	Months	Days	If LESS than 1 day,
	69			..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Mich

PARENTS

10. NAME OF FATHER Monroe Wemberg
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn
12. MAIDEN NAME OF MOTHER Sarah Bramer
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Penn

14. Informant L C. Wemberg
(Address) Wendell Ida

15. Filed Oct 22, 1930 C. L. Simonton
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15, 1930, to Oct 18, 1930
that I last saw him alive on Oct 18, 1930
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows: Influenza, pneumonia

.....(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) C. L. Simonton M. D.
Oct 22, 1930 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
Wendell, Cem.	
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED JAN 2 0 1931

58b

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73725

PLACE OF DEATH

County of Gooding

City of Wendell R.F.D.

CERTIFICATE OF DEATH

Registration District No. 22

Primary Registration District No. 2015

(No. .....)

Local Registrar's No. .....

(If death occurred in a hospital or institution give its name instead instead of street and number.)

2. FULL NAME James B. Goddard

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If ~~married, widowed,~~ or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year)

7 AGE: Years 15 | Months 6 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Michigan

PARENTS

10 NAME OF FATHER: Ora Goddard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Michigan

12 MAIDEN NAME OF MOTHER: Bernice Kaizer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mich.

14 Informant: Ora Goddard
(Address) Wendell Ida.

15 Filed Sep 26, 1930 E. L. Simonton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 9 (Month) 25 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sep 18, 1930, to Sep 25, 1930, that I last saw him alive on Sep 25, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:
Aplastic anemia

(duration) ..... yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary): Influenza

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Biological blood

(Signed) E. L. Simonton M. D.

Sep 26, 1930 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal: Twin Falls Ida

Date of Burial: 9-27 1930

20. Undertaker: White Mortuary

Address: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

869

RECEIVED JAN 2 [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73726

PLACE OF DEATH.
County of Gooding
City of Wendell

Registration District No.
Primary Registration District No.
Local Registrar's No.
(No. St. Valentine Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Joy Elizabeth Tacy

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan 26 1930

7. AGE	Years	Months	Days	If LESS than 1 day,
	—	9	3	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Dietrich Idaho

PARENTS

10. NAME OF FATHER E E Tacy
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wisconsin
12. MAIDEN NAME OF MOTHER Maude Weiss
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Edison Neb.

14. Informant E E Tacy
(Address) Dietrich Ida.

15. Filed Jan 13, 1931 C. L. Simonton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 29 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20, 1930, to Oct 29, 1930
that I last saw he alive on Oct 29, 1930
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Atrepsia due to
middle ear infection
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) John F. Schmeckebier M. D.
Oct 29, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Shoshone Ida	Oct 31 1930

20. Undertaker	Address
E E Fickett	Shoshone Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

RECEIVED [illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73729

PLACE OF DEATH
County of Gooding Registration District No. 72
City of Wendell Primary Registration District No. 2018 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Elizabeth Jane Burnie

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of George Burnie

6. DATE OF BIRTH (month, day and year) Oct 22 1836

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	94			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) White County Illinois

PARENTS

10. NAME OF FATHER Joshua Davis

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or County)

14. Informant Laura M. Haynes (Address)

15. Filed Dec 27, 1930 E. L. Simonton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 25, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17, 1930, to Dec 25, 1930
that I last saw her alive on Dec 17, 1930
and that death occurred, on the date stated above, at 7:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bronchitis & inanition
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) E. L. Simonton M.D.
, 19 (Address)

19. Place of Burial, Cremation, or Removal	Date of Burial
Wendell Ida	Dec 27 1930
20. Undertaker	Address
David L. Merriam	Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

99c

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 2 [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 73730

Registered No.

1. PLACE OF DEATH

County of Jerchino

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Victor Clare Bailey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1930 (Year)

7. AGE: ..... Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wendell Ida

10. NAME OF FATHER: Marion E. Bailey

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Romaine Siebold

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. E. Bailey

(Address) Wendell Ida

15. Filed Nov 27 1930 E. L. Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1930 to Nov 26 1930 that I last saw h. him alive on Nov 26 1930, and that death occurred on the date stated above, at 3:40 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis with
pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Simonton M. D.

11-27 1930 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida

DATE OF BURIAL: Nov 29 1930

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JAN 26 1931

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 73731

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Putnam Albee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 9 (Day) 1856 (Year)

7. AGE: 74 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Joseph P Albee

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Caltha Putnam

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Laura Albee

(Address): Wendell Ida

15. Filed Nov 20 1930 E L Simonton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1930 to Nov 18 1930 that I last saw him alive on Nov 18 1930 and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E L Simonton M. D.

11-20 1930 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: 11-22 1930

20. UNDERTAKER: L Herriman — ADDRESS: Jerome Ida

FORM V. S. No. 5-25 M. 1-19

RECEIVED JAN 29 1931

CERTIFICATE OF DEATH

124

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 73735

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Wendell

(No. ..... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarsey Jane Crouse

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 1 (Day) 1862 (Year)

7. AGE: 68 Yrs. 9 Mos. 18 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Bates

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Sarah Baldridge

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. F. Crouse

(Address) Wendell Idaho

15. Filed Oct 20 1930

E. L. Simonton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1930 to Oct 19 1930

that I last saw her alive on Oct 19 1930

and that death occurred on the date stated above, at 12 30 P. M.

The CAUSE OF ~~DEATH~~* was as follows:

Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Gallbladder infection

(Duration) yrs. mos. ds.

(Signed) E. L. Simonton M. D.

10-19-1930 (Address) Wendell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

RECEIVED JAN 2 [illegible]

128

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73736

PLACE OF DEATH
County of Gooding
City of Wendell
Registration District No. 22
Primary Registration District No. 2018
Local Registrar's No.
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Laurence Gilbert Gates

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Nov 12 1917

7. AGE: Years 12 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wendell Idaho

PARENTS

10. NAME OF FATHER: Richard Gates
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Huntsville Arkansas
12. MAIDEN NAME OF MOTHER: Della Gates
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bentonville Arkansas

14. Informant: Thomas Gates
(Address) Wendell Ida

15. Filed Sep 19, 1930 E L Dimmick
Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 18 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 16, 1930 to Sep 18 1930
that I last saw him alive on Sep 18, 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows: Uremic poisoning

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Influenza
(duration) yrs. mos. 3 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Chemical
(Signed) E L Dimmick M.D.
Sep 19, 1930 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A-25M. 1-19.

RECEIVED FEB 3 1931

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

State File No. 73738

Local Registrar's No. 149

Registration District No. 24

Primary Registration District No.

1. PLACE OF DEATH
County of Gooding
City of (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delvin Glenn Bruner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1930 (Year)

7. AGE: Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Lloyd a Bruner

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Lula Snoderly

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Lula Bruner
(Address): Gooding

15. Filed 1/31-31 19 J H Conwell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Unknown- found dead in bed- No previous illness

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Conwell M. D.
19..... (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. ..... mos. ..... days. In the State..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Ida	12-30-1930
20. UNDERTAKER	ADDRESS
H E Thompson	Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 14 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73743

PLACE OF DEATH
County of Franklin
City of Preston

Registration District No. 83
Primary Registration District No. 2160
Local Registrar's No. 2
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Stella M. Hadley

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

51

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Willard Hadley

6. DATE OF BIRTH (month, day and year) Sept 21 1902

7. AGE Years 28 Months 2 Days 21 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Clifton Idaho

PARENTS
10. NAME OF FATHER I W Mickelson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dayton Idaho
12. MAIDEN NAME OF MOTHER Leona Morrison
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dayton Idaho

14. Informant (Address) Nora Durant
Franklin Idaho

15. Filed Feb-12, 1931 Mary C. Coffin Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2 (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-1, 1930, to 12-21, 1930
that I last saw her alive on 12-21 1930
and that death occurred, on the date stated above, at 5 30 m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Bright's disease
Pregnancy
..... (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Confinement
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) A. K. Poole, M. D.
....., 19..... (Address) .....

19. Place of Burial, Cremation, or Removal Swan Lake Idaho
Date of Burial Dec 22 30 19

20. Undertaker M. W. Hendricks Preston
Address

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 13747

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise
Registration District No. 3
Primary Registration District No. 1007
Local Registrar's No. 3
(No. St. Lukes Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Sarah C. Endsley
(a) Residence. No. 1007 Grant St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Henry E. Endsley

6. DATE OF BIRTH (month, day and year) April 18-1848

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	8	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Lexington Va

PARENTS

10. NAME OF FATHER Samuel Woods
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Va.
12. MAIDEN NAME OF MOTHER Not obtainable
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Va.

14. Informant T. A. Endsley
(Address) 1529 Vermont Ave Boise Ida

15. Filed 1-3 31 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 31 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1930, to Dec 30, 1930
that I last saw her alive on Dec 30, 1930
and that death occurred, on the date stated above, at 1 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Fracture of right Femur in surgical neck Caused by a fall.
Senile Coronary Embolism (probable)
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) 4 months
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? at her home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) P P Bergen M. D.
Jan 2, 1930 (Address) Boise Idaho

19. Place of Burial, Cremation or Removal: Morris Hill Cemetery — Date of Burial: 1/2 1931

20. Undertaker: Schreiber & McCann — Address: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

French

3

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED FEB 10 1931

DO NOT WRITE IN THIS SPACE
State File No. 73748

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. X 2
Primary Registration District No. X 1004 Local Registrar's No. X
(No. 614 Front)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wong Kew

(a) Residence. No. 216 [illegible] 7th St. St. 164
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Chinese	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
95	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) China

PARENTS
10. NAME OF FATHER Chin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) China
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) (State or County) China

14. Informant (Address) Harry W. Yen Boise Idaho

15. Filed 1-3, 1931 W. H. Rodden Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility

.....(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (Secondary) .....
.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of.....
Was there an autopsy?.....
What test confirmed diagnosis?.....
(Signed) Geo Cathcart M. D.
....., 19..... (Address).....

19. Place of Burial, Cremation, or Removal	Date of Burial
Chinese Cemetery	Jan 19

20. Undertaker Schreiber & McCann Address 12/31/30

U. S. A. D. A. C. R. Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED FEB 10 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73750

PLACE OF DEATH
County of Ada
City of Boise

Registration District No. 2
Primary Registration District No. 1004
Local Registrar's No. 12
(No. St Alphonsus)
(If death occurred in a hospital or institution, give its name instead of street and number.)

164

2. FULL NAME Martin Tobert
(a) Residence. No. Fruitland Ida St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. 5 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) — — —

7. AGE about Years 80 Months Days If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Crimea Russia

PARENTS
10. NAME OF FATHER No Record
11. BIRTHPLACE OF FATHER (city or town) (State or Country) No Record
12. MAIDEN NAME OF MOTHER No Record
13. BIRTHPLACE OF MOTHER (city or town) (State or County) No Record

14. Informant (Address) Lenie Grischkowsky Fruitland Idaho

15. Filed 1-8, 1931 W. H. Rhodes Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 31 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Dec 31, 1930
that I last saw him alive on 12/28, 1930
and that death occurred, on the date stated above, at ....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Senility

....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
....(duration) ....yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical finding
(Signed) Fred A Pettengill, M. D.
1/3, 1930 (Address) Boise

19. Place of Burial, Cremation, or Removal Morris Hill Cemetry
Date of Burial 1-3 1931

20. Undertaker Schreiber McCann
Address Boise Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

41

RECEIVED JAN 2 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73797

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 117

2. FULL NAME Reino Alfred Takanen
(a) Residence. No. Prichard Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: which
5. Single, Married, Widowed, or Divorced (write the word): single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —
6. DATE OF BIRTH (month, day and year) Oct. 29 1909
7. AGE Years 21 Months 1 Days 10 If LESS than 1 day, ... hrs. or ... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Forrest Service
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Michigan City Michigan

PARENTS
10. NAME OF FATHER Emil Takanen
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Finland
12. MAIDEN NAME OF MOTHER Alina Kingelin
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Finland

14. Informant Eva Takanen
(Address) Prichard Ida
15. Filed Dec 12, 1930 F. L. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 2, 1930, to Dec 9, 1930
that I last saw him alive on Dec 1930
and that death occurred, on the date stated above, at 3:45 a.m.
The CAUSE OF DEATH* was as follows:
Septicaemia General
(duration) yrs. 4-5 ds.
CONTRIBUTORY (Secondary) Appendicitis, peri
Sonitis (duration) yrs. mos. 9 ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec 2
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Drs Mowery, M. D.
12/9, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Wallace, Idaho
Date of Burial: Dec 12 1930
20. Undertaker: Bruce G. Norstell
Address: Wallace

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73798

PLACE OF DEATH
County of Shoshone JAN 23 1931
City of Wallace
Registration District No. 70
Primary Registration District No. 1011 Local Registrar's No. 121
(No. Wallace Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ethel M Musson
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Minn

PARENTS
10. NAME OF FATHER Not Known
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Not Known

14. Informant (Address) Mr Al Slosson Wallace Idaho

15. Filed Dec 28, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 27 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from NOV 5, 1930, to Dec 27, 1930
that I last saw her alive on Dec 27, 1930
and that death occurred, on the date stated above, at 7 A. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? laboratory blood examination
(Signed) R. Werlich, M. D.
Dec 27, 1930 (Address) Wallace Idaho

19. Place of Burial, Cremation, or Removal Puyallup, Wash Date of Burial Shipped Dec 28 1930
20. Undertaker J. A. Dever Wallace Idaho Address Wallace, Ida

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

RECEIVED JAN 23 1931

DO NOT WRITE IN THIS SPACE
State File No. 73801

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011 Local Registrar's No. 23
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Winnefred Presley
(a) Residence. No. Wallace, Idaho St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White.
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6. DATE OF BIRTH (month, day and year) July 29 - 1858

7. AGE Years 72 Months 5 Days 0 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Buffalo N.Y.

PARENTS
10. NAME OF FATHER Chas McCauley.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Winnefred Hayden
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ireland

14. Informant (Address) Mr Clarence Presley Wallace Idaho

15. Filed Jan 2, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 29 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12, 1930, to Dec 29, 1930
that I last saw her alive on Dec 29, 1930
and that death occurred, on the date stated above, at 4 P.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebrospinal sclerosis
(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont know of any
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
12/30 (Signed) Dr. Mowary M.D.
1930 (Address) Wallace Idaho

19. Place of Burial, Cremation, or Removal Spokane Wash Date of Burial Jan 2 1930

20. Undertaker J. A. Bever Ward Und. Co. Address Wallace Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED FEB 7 1931

DO NOT WRITE IN THIS SPACE
State File No. 73808

PLACE OF DEATH
County of Shoshone
City of Kellogg

Registration District No. 123
Primary Registration District No. 2201
Local Registrar's No. 1
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Martha Isabelle Fields

(a) Residence. No. ..... Kellogg Idaho St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) July 24, 1860

7. AGE Years	Months	Days	If LESS than 1 day,
70	5	6	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Illinois
(State or country)

PARENTS

10. NAME OF FATHER None
11. BIRTHPLACE OF FATHER (city or town) (State or Country) None
12. MAIDEN NAME OF MOTHER Martha Isabelle Bryant
13. BIRTHPLACE OF MOTHER (city or town) Springfield (State or Country) Illinois

14. Informant Mrs. Jesse Carpenter
(Address) Kellogg Idaho.

15. Filed Jan 4, 1931. Wm. Helen McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1930, to Dec 30, 1930, that I last saw her alive on Dec 30th, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? Spokane Wash.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptomatology
(Signed) W. C. Linden, M. D.
Jan 3rd, 1931 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Garfield Wash	Jan 5, 1931
20. Undertaker	Address
M. C. Trumbull	Kellogg Ida

TION is very important. See instruction on back of certificate.

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STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED JAN 23

DO NOT WRITE IN THIS SPACE

State File No. 73809

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1011 Local Registrar's No. 114

(No. Providence Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Walter Raymond Arms

(a) Residence. No. Burke Idaho St. Burke, Idaho

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov - 29 - 1930

7. AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10. NAME OF FATHER Elbridge Arms

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Mich

12. MAIDEN NAME OF MOTHER Maimie Gilstrap

13. BIRTHPLACE OF MOTHER (city or town) (State or County) S. D.

14. Informant (Address) Mr E Arms Burke Idaho

15. Filed Dec 4, 1930 H. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29, 1930, to Dec 2, 1930

that I last saw him alive on Dec 2, 1930

and that death occurred, on the date stated above, at 8:40 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Morbus maculosis neonatorum

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) not determined

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Quigley, M. D.

12/2, 1930 (Address) Wallace Ida

19. Place of Burial, Cremation, or Removal Wallace Idaho. Date of Burial Dec 4 1930

20. Undertaker J. A. Bever Ward Und Co. Address Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 73810

PLACE OF DEATH

County of Shoshone

City of Mullan

Registration District No. .....

Primary Registration District No. .....

Local Registrar's No. 19

(No. residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Herbert Jackson

(a) Residence. No. Mullan, Idaho St. Mullan, Idaho

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov - 9 - 1917

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
13	1	9	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mullan Idaho

PARENTS

10. NAME OF FATHER John Jackson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iago Slavia.

12. MAIDEN NAME OF MOTHER Mary Tshier

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Iago Slavia.

14. Informant John Jackson
(Address) Mullan Ida.

15. Filed Dec 20, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 18 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/6/30, 19..., to 12/18/30, 19...

that I last saw him alive on ..... 19... and that death occurred, on the date stated above, at 8:10 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Sarcoma left Kidney
(Metastasis of Brain)

(duration) 12 (?) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

12/18/30 (Signed) James R Bean, M. D.

19 (Address) Mullan

19. Place of Burial, Cremation, or Removal: Mullan Idaho. Date of Burial: Dec 20 19

20. Undertaker J. A Bever Ward and Co. Address Wallace Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

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STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED JAN 23 1931

DO NOT WRITE IN THIS SPACE

State File No. 73811

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Shoshone

City of Gem

Registration District No. 70

Primary Registration District No. 1011 . Local Registrar's No. 120

(No. Residence)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME James Franklin Thompson

(a) Residence. No. Gem, Idaho St. Gem Idaho

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) Feb - 20 - 1903

7. AGE Years 27 Months 10 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Front Mining Co.

9. BIRTHPLACE (city or town) (State or country) Mo.

PARENTS

10. NAME OF FATHER Jim Thompson

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Lillian Stanton

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill.

14. Informant (Address) Mrs Jim Thompson. Gem Idaho

15. Filed Dec 27, 1930 F. L. Quigley Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 1929, to Dec 24, 1930

that I last saw him alive on Dec 20, 1930

and that death occurred, on the date stated above, at 1 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Sarcoma Testicle left & region

(duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Injury

(duration) Several ago

18. Where was disease contracted if not at place of death? Butte Mont

Did an operation precede death? Yes Date of Don't know

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D. Mowery Corona

Dec 24, 1930 (Address) Wallace Ida

19. Place of Burial, Cremation, or Removal Wallace Idaho

Date of Burial Dec 27 1930

20. Undertaker J. A. Bever Ward Und Co.

Address Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

FORM. V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

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State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 73812
Registered No. 26

RECEIVED JAN 23 1931

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Arnold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
3 (Month) 12 (Day) 1857 (Year)

7. AGE
74 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Germany.

10. NAME OF FATHER Otto Arnold.

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Olga Arnold.

13. BIRTHPLACE OF MOTHER
(State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. M. Boggs
(Address) County Infirmary

15.
Filed Dec 10 1930
L. L. Quick Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
12 (Month) 8 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-13- 1929, to 12-8- 1930, that I last saw h-- alive on 12-8- 1930, and that death occured on the date stated above, at 11:50 M.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

1½ (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chr. Myocarditis - Arteriosclerosis

4 yrs (Duration) ..... yrs. ..... mos. ..... ds.

12/11 1930. (Signed) James R Brian M. D.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 7 mos. 15 days. In the State 46 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?.....
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho
DATE OF BURIAL: Dec 13 1930

20. UNDERTAKER: M. S. Thornhill
ADDRESS: Kellogg, Idaho

(1-23-31)

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73813

PLACE OF DEATH
County of Shoshone
City of Kellogg
Registration District No. 70
Primary Registration District No. 1011
(No. Caldwell)
Local Registrar's No. 113
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Dewaine Walker
(a) Residence. No. Kellogg St. Ida
(Usual place of abode.)
Length of residence in, city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State.) Kellogg Idaho

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Wallace Idaho

PARENTS

10. NAME OF FATHER Everett Walker
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Tacoma Wash
12. MAIDEN NAME OF MOTHER Violet Monroe
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Idaho

14. Informant (Address) Mrs Everett Walker Kellogg Idaho

15. Filed Dec 4, 1930 F. L. Quigley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 1 30
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on Nov 28, 1930
and that death occurred, on the date stated above, at 5 A.M.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Sudden death Natural Causes
Probably "Lymphatic Diathesis"

(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Cerebral Arrest
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) James R Dean, M. D.
12/1/30, 19..... (Address) Wallace

19. Place of Burial, Cremation, or Removal	Date of Burial
Wallace, Idaho	12/4 1930
20. Undertaker C. A. Bever Ward Undertaking Co.	Address Wallace, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 8 1931

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73814

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 118

2. FULL NAME Robert J. Meek,
(a) Residence. No. Rose Lake, Idaho St. Rose Lake, Idaho,
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word) married

5a. If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary R. Meek

6. DATE OF BIRTH (month, day and year) May 9th 1877.

7. AGE Years 53 Months 7 Days 2 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Brownwood
(State or country) Texas

PARENTS
10. NAME OF FATHER John S. Meek
11. BIRTHPLACE OF FATHER (city or town) Tennessee
(State or Country)
12. MAIDEN NAME OF MOTHER Emily Sloudge
13. BIRTHPLACE OF MOTHER (city or town) Tennessee
(State or Country)

14. Informant Mrs Mary R. Meek
(Address) Rose Lake, Idaho

15. Filed Dec 14, 1930 F. L. Dingley Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1928, to Dec 11, 1930
that I last saw him alive on Dec 11, 1930
and that death occurred, on the date stated above, at 10 p.m.
The CAUSE OF DEATH* was as follows: Myocardetis Chr
(duration) Several yrs. mos. ds.
CONTRIBUTORY (Secondary) Dementia Paralytica
(duration) Several yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Dec
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Drs Mowery, M. D.
12/12, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Rose Lake, Cemtry. Date of Burial Dec. 14 1930

20. Undertaker Bruce G. Worstell Address Wallace

7 / 9

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73815

RECEIVED JAN 2 1931

PLACE OF DEATH
County of Shoshone
City of Wallace

Registration District No. 70
Primary Registration District No. 1011
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 122

2. FULL NAME Emma Marie Lennon

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Infant

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Dec 22-1930

7. AGE — Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Wallace Ida

PARENTS

10. NAME OF FATHER: Patrick Lennon
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Elizabeth Gallagher
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14. Informant: Patrick Lennon
(Address): Kellogg Ida

15. Filed Jan 3, 1931 — F. L. Quigley, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/22, 1930 to Dec 28, 1930 that I last saw her alive on Dec 27th, 1930 and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Forceps delivery
(duration) yrs. mos. 6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Symptomatology

(Signed) W. L. Lindsay, M. D.
12/29, 1930 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kellogg Ida — Date of Burial: Dec 29 1930

20. Undertaker: P. L. Saint — Address: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73816

RECEIVED JAN 8 1931

PLACE OF DEATH
County of Shoshone
City of Wallace
Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 115
(No. Dewey Street)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Polonia Fernandez
(a) Residence. No. Mullan Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Bony Fernandez

6. DATE OF BIRTH (month, day and year): Feby 9 1871

7. AGE: Years 59 | Months 9 | Days 24 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (city or town) (State or country): Bedarona Spain

PARENTS

10. NAME OF FATHER: Francisco Mallea
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Lorenza Barainca
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Spain

14. Informant: Mrs. Jose Liguridia
(Address): Mullan Idaho

15. Filed Dec 4, 1930 — F. L. Lee, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 2 (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20, 1930, to Dec 2, 1930, that I last saw h alive on Dec 2, 1930, and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows: Cardiac Cerebral Hemorrhage

(duration) yrs. 4 mos. 2 wks ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Dr. McVay, M. D.
12/3, 1930 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Nampa, Idaho — Date of Burial: Dec 4 1930

20. Undertaker: R. G. Worstell — Address: Wallace

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73825

RECEIVED JAN 30 1931

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 84
Primary Registration District No. 1212 Local Registrar's No. 1

Sussana (No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Susanna M. Dawson

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word.) Widowed

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of P. P. Dawson

6. DATE OF BIRTH (month, day and year) May 23 - 1845

7. AGE 85 Years | Months 6 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewood
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Tazewell Co.
(State or country) Virginia

PARENTS
10. NAME OF FATHER Joseph Day
11. BIRTHPLACE OF FATHER (city or town) Dont Know
(State or Country)
12. MAIDEN NAME OF MOTHER Adeline Harris
13. BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or County)

14. Informant (Address) Charles Crowe Weiser Idaho

15. Filed Jan 3, 1931 M. P. Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Senility, died before medical assistance arrived
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) L. C. Northam Coroner ~~M. D.~~
Dec 20, 1930 (Address) Weiser Ida

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery | Date of Burial 12-21-1930

20. Undertaker L. C. Northam | Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 30 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

128 7

DO NOT WRITE IN THIS SPACE
State File No. 73826

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010 Local Registrar's No. 6
(No.)
(If death occurred in a hospital or institution give its name instead of street and number.)

2. FULL NAME Edgar Wallace Mack

(a) Residence. No. New Meadows St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	Wht	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Ella Mack

6. DATE OF BIRTH (month, day and year) Feb. 11 - 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74		5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10. NAME OF FATHER John Mack
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Penn.
12. MAIDEN NAME OF MOTHER Anna Wallace
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Penn

14. Informant (Address) H.C. Mack Weiser Ida

15. Filed Jan 29, 1931 W.R. Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 16 (Day), 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 7th, 1931, to Jan - 16 -, 1931 that I last saw him alive on Jan - 15th 12 a.m. 1931 and that death occurred, on the date stated above, at 7:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute Glomerular Nephritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cardio-Renal Insufficiency disease (duration) 15 yrs. mos. ds.

18. Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of
Was there an autopsy? Yes What test confirmed diagnosis? Laboratory and Clinical

(Signed) R.W. French, M. D.
Jan - 16 -, 1931 (Address) Huntington Ore.

19. Place of Burial, Cremation, or Removal	Date of Burial
Nearest Cemetery	1 - 18 1931
20. Undertaker L.C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED JAN 30 1931

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73827

PLACE OF DEATH
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010 Local Registrar's No. 5
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harriett Lucille Broadbent
(a) Residence. No. 853 W 3rd St St. (If nonresident give city or town and State.)
(Usual place of abode.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE Wht
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of E H Broadbent

6. DATE OF BIRTH (month, day and year) Feb 23 - 1912

7. AGE Years 18 Months 10 Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Idaho

PARENTS
10. NAME OF FATHER Harvey Thomason
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Dont Know
12. MAIDEN NAME OF MOTHER Ina Reeves
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dont Know

14. Informant (Address) E H. Broadbent Weiser Idaho

15. Filed Jan. 29, 1931 W R Hamilton Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 13 (Day), 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-12-, 1931, to Jan-13th-, 1931
that I last saw her alive on Jan-13th-, 1931
and that death occurred, on the date stated above, at 4:15 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Acute Nephritis with uremia and convulsions, five days post-partum
(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis - Glomerular
(duration) yrs. mos. 10 ds.

18. Where was disease contracted if not at place of death? at Home Weiser Ida
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical and laboratory
(Signed) K M Fouch M. D.
Jan-13, 1931 (Address) Huntington Ore

19. Place of Burial, Cremation, or Removal Hillcrest Cemetery Date of Burial 1-16-1931

20. Undertaker L. C. Northam Address Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

RECEIVED JAN 30 1931

DO NOT WRITE IN THIS SPACE

State File No. 73831

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Washington

City of Weiser

Registration District No. 84

Primary Registration District No. 2112

Local Registrar's No. 2

(No.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Jasper Willburn

(a) Residence. No. St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	Wh	married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Willburn

6. DATE OF BIRTH (month, day and year) Feb 22 1836

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
94	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer & Stock Raiser
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Mo

PARENTS

10. NAME OF FATHER Wiggins Williams

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ga

12. MAIDEN NAME OF MOTHER Cherby Williams

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Mo

14. Informant (Address) Mrs Mary Willburn Weiser Idaho

15. Filed Jan 3, 1931 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 29, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1900, 19..., to Dec 28, 1930
that I last saw him alive on Dec 28, 1930
and that death occurred, on the date stated above, at 12 30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) J. R. Woodward, M. D.
1/1/31, 19... (Address) Payette, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Hillcrest Cemetery	1-2-1931
20. Undertaker L. C. Northam	Address Weiser Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED FEB 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73846

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Edgar Charles.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 29 1861

7. AGE: Years 69 | Months 8 | Days 19 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Dairy Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Richmond Indiana

PARENTS

10. NAME OF FATHER: Joel Charles,
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Mary Wilkerts
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Indiana

14. Informant (Address): Mrs. E. Charles Bonners Ferry, Ida

15. Filed Dec. 19, 1930 E. [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 18 (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec., 1929, to Dec. 18, 1930
that I last saw him alive on Dec. 18, 1930
and that death occurred, on the date stated above, at 10:30 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no.
What test confirmed diagnosis? Urine & history.
(Signed) E. E. [illegible], M. D.
Dec. 19, 1930 (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal: Bonners Ferry, Ida. Date of Burial: Dec 22 1930

20. Undertaker: H. R. Crouch, Bonners Ferry Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73847

PLACE OF DEATH
County of Boundary
City of Bonners Ferry

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No. .....
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harold Oakley Jackson
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 21 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Phoebe Jackson

6. DATE OF BIRTH (month, day and year) July 14, 1879

7. AGE Years 51 Months 5 Days 5 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) East Middlesex Ontario, Canada

PARENTS
10. NAME OF FATHER Joseph Jackson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ontario.
12. MAIDEN NAME OF MOTHER Rhoda Bratt
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ontario.

14. Informant (Address) Mrs. Phoebe Jackson Bonners Ferry, Ida.

15. Filed Dec 19, 1930. [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 19, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1930, to Dec 19, 1930
that I last saw him alive on Dec 19, 1930
and that death occurred, on the date stated above, at 8 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) 10 yrs. mos. ds.
CONTRIBUTORY (Secondary) Uremia
(duration) yrs. mos. 1 ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis Laboratory & Physical Examination
(Signed) Rue Bowell, M. D.
Dec 19, 1930 (Address) Bonners Ferry Ida

19. Place of Burial, Cremation, or Removal Bonners Ferry Ida
Date of Burial Dec. 22 1930

20. Undertaker H. R. Crouch, Bonners Ferry
Address

RECEIVED FEB [illegible] 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
117
State File No. 73848

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boundary

City of Bonners Ferry

Registration District No. 79

Primary Registration District No. 2156 Local Registrar's No. .....

(No. Bonners Ferry Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George William Langton

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 9, 1919.

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	1	21	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At school
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) ..... (State or country) Canada

PARENTS

10. NAME OF FATHER William H. Landton

11. BIRTHPLACE OF FATHER (city or town) ..... (State or Country) England

12. MAIDEN NAME OF MOTHER Marie Craven

13. BIRTHPLACE OF MOTHER (city or town) ..... (State or County) England.

14. Informant Mrs. W.H. Langton,
(Address) Bonners Ferry, Idaho.

15. Filed Dec. 30 - 1930. ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 30, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1930, to Dec 30, 1930

that I last saw him alive on Dec 30, 1930

and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Acute gangrenous appendicitis
with abscess & peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Dec 30-1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Lin Bonnell, M. D.

Dec 30, 1930. (Address) Bonners Ferry Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida.	Jan. 2, 1931

20. Undertaker H.R. Crouch, Bonners Ferry.

Address .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 73849

RECEIVED DEC 31 1930

PLACE OF DEATH **CERTIFICATE OF DEATH**

County of Boundary Registration District No. 79

City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No. .....

(No. Bonners Ferry Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Pearl Marie Pennigo

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) March 23 - 1922

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	8	9	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10. NAME OF FATHER Roy Pennigo

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Fannie Stephenson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Missouri

14. Informant Mrs. Fannie Pennigo
(Address) Bonners Ferry, Ida.

15. Filed Dec. 30, 1930 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10, 1930, to Dec 30, 1930

that I last saw her alive on Dec 29, 1930

and that death occurred, on the date stated above, at 5 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Acute perforative appendicitis

Peritonitis

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) ..... yrs. 2 mos. ..... ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 12

Was there an autopsy? No

What test confirmed diagnosis Operation & Physical Exam.

(Signed) R. M. Bourke, M. D.

Dec 30, 1930 (Address) Bonners Ferry Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Bonners Ferry, Ida	Dec. 31, 1930
20. Undertaker	Address
H. P. Crouch, Bonners Ferry	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
Exact statement of OCCUPATION is very important. See instructions on back.
PHYSICIAN
MARGIN RESERVED FOR BINDING

RECEIVED FEB 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73850

PLACE OF DEATH

County of Boundary
City of Bonners Ferry

CERTIFICATE OF DEATH

Registration District No. 79
Primary Registration District No. 2156 Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Benjamin D. Ryan

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 9, 1874

7. AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
56	7	25	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Railway Conductor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Spokane International Ry.

9. BIRTHPLACE (city or town) (State or country) South Bend Indiana

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Unknown

14. Informant (Address) Railway Personal Record s

15. Filed Dec. 4, 1930. E. E. Fry Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 3, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 28th, 1930, to Dec. 3rd, 1930
that I last saw him alive on Dec. 2nd, 1930
and that death occurred, on the date stated above, at 2 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) E. E. Fry, M. D.
Dec. 4, 1930 (Address) Bonners Ferry, Ida

19. Place of Burial, Cremation, or Removal: Spokane, Wash. Date of Burial 19

20. Undertaker: H.R. Crouch, Bonners Ferry, Ida. Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED FEB [illegible] 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 73851

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Boundary Registration District No. 79

City of Bonners Ferry Primary Registration District No. 2156 Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** George Frederick Gleed

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Delia Gleed.

6. DATE OF BIRTH (month, day and year) January 9th 1859

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	11	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Post Master
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Appleton Wisconsin

PARENTS

10. NAME OF FATHER Thomas Gleed

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) Mrs. G. F. Gleed Bonners Ferry

15. Filed Dec. 5 - 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 7th. (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1930, to Dec. 7 - 1930 that I last saw him alive on Dec. 6 - 1930 and that death occurred, on the date stated above, at 2:30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows

Carcinoma of left lung.

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Hydronephrosis.

(duration) 3 yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? Yes. Date of 1927.
Was there an autopsy? No.
What test confirmed diagnosis? History and Symptoms. Examination

(Signed) [signature] M. D.
Dec. 8 - 1930 (Address) Bonners Ferry, Ida.

19. Place of Burial, Cremation, or Removal Bonners Ferry, Ida. Date of Burial Dec. 9 1930

20. Undertaker W. P. Crouch, Bonners Ferry, Ida. Address .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED FEB 9 1931

DO NOT WRITE IN THIS SPACE
State File No. 73853

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Jerome
City of Jerome

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Ella Armanda Stanton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word): married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clark T. Stanton

6. DATE OF BIRTH (month, day and year) April 2 - 1860

7. AGE: Years 70, Months 8, Days 19. If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Woodburn, Oregon

PARENTS
10. NAME OF FATHER: Isac W. Garrett
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Welch
13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Clark T. Stanton
(Address) Jerome Idaho

15. Filed 1/15, 1931 Chas F. Zeller Registrar

MEDICAL CERTIFICATE OF DEATH 57

16. DATE OF DEATH: December 31 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1930, to Dec 31, 1930
that I last saw her alive on 1 or p Dec 31, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Coma
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Urine
(Signed) John Schmerstall M. D.
Jan 5, 1931 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: Jan 1 1931

20. Undertaker: D A J Herrisson
Address: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED FEB 6 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73867

PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 78

Primary Registration District No. 2155

(No. Parnell Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Carl Wickstrom

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Jan. 26, 1884

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	10	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14. Informant Parnell Hospital

(Address) Sandpoint, Idaho.

15. Filed Jan 5, 1931 Viola Allen Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 3, (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1, 1930, to Dec 3, 1930

that I last saw h~~is~~ alive on Dec 2, 1930

and that death occurred, on the date stated above, at 7:10 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Floyd Glendle M. D.

Jan. 5, 1931 (Address) Sandpoint, Idaho.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Pinecrest Cemetery	Jan. 7, 1931

20. Undertaker	Address
R. E. Wessa	Priest River Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73868

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 49
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mrs Elizabeth Rachel Weindle

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
female	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas J. Weindle

6. DATE OF BIRTH (month, day and year) Dec 22 - 1866

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64		2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: home wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10. NAME OF FATHER Jacob Yontzler
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Virginia Woosley
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Kentucky

14. Informant (Address) Mrs Bernard Weindle Payette Idaho

15. Filed Dec 31, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1930, to Dec 24, 1930, that I last saw her alive on Dec 12, 1930 and that death occurred, on the date stated above, at 4a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? yes Date of Sept 10 1930
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas E Palmer, M. D.
Dec 30, 1930 (Address) Ontario Ore

19. Place of Burial, Cremation, or Removal: Payette Idaho — Date of Burial: Dec 26 1930
20. Undertaker: Glenn C Sanders — Address: Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73869

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 50
59
(No.)
(If death occurred in a hospital or institution, give its name instead of [illegible] and number.)

RECEIVED JAN 17 1931

2. FULL NAME Adilbert H Christian
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Christian

6. DATE OF BIRTH (month, day and year) Sept 14-1879

7. AGE Years 51 Months 3 Days 10 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fruit Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kans

PARENTS
10. NAME OF FATHER Joseph Christian
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Morris
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill

14. Informant (Address) Earl W Christian Payette Ida

15. Filed Dec 31, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27, 1930, to Dec 24, 1930
that I last saw him alive on Dec. 24, 1930
and that death occurred, on the date stated above, at 5 P. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Tumor. Pituitary gland.

indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? yes.
What test confirmed diagnosis? autopsy
(Signed) Merrill R. Fox, M. D.
Dec. 25, 1930 (Address) Payette Ida

19. Place of Burial, Cremation, or Removal Payette Ida
Date of Burial Dec 26 1930

20. Undertaker O. H. Adair
Address Peterson Furn Co Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73870

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 44
(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Glenn Lindsey
RECEIVED JAN 17 1931
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word.) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) -1916
7. AGE Years 14 Months 10 Days If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Ida
PARENTS
10. NAME OF FATHER Arch Lindsey
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Colo
12. MAIDEN NAME OF MOTHER Pearl Howard
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill Iowa
14. Informant (Address) C. E. Howry
15. Filed Dec 6, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 6, 1930 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1930, 19, to Dec 5, 1930, 19
that I last saw him alive on Dec 5, 1930, 19
and that death occurred, on the date stated above, at 6.00 m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 12/5/30
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) J. C. Woodward M. D.
12/6/30, 19 (Address) Payette Id
19. Place of Burial, Cremation, or Removal Manns Creek Cem Date of Burial Dec 8 1930
20. Undertaker J. O. Hedan Address Peterson Furn Co Payette Ida

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73871

PLACE OF DEATH
County of Payette
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 46
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Mrs Zelma Francis

(a) Residence. No. 207 3rd Ave N 4th St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): married

a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Francis

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 26 — Months — Days — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Ida

PARENTS

10. NAME OF FATHER: Brett Bent
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Ida
12. MAIDEN NAME OF MOTHER: Johnson
13. BIRTHPLACE OF MOTHER (city or town) (State or County): unknown

14. Informant (Address): Henry Francis

15. Filed Dec 31, 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10th (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 6, 1930, to Dec 10, 1930, that I last saw her alive on December 10, 1930, and that death occurred, on the date stated above, at 10 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Double lobar pneumonia - 4 days

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Child birth, Dec 6 1930

(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) O. H. Avery, M. D.
Dec 15, 1930. (Address) Payette Ida

19. Place of Burial, Cremation, or Removal: Payette Idaho — Date of Burial: Dec 14 1930

20. Undertaker: Glenn C Sanders — Address: Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

101b

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED JAN 1 ... 1931

DO NOT WRITE IN THIS SPACE
State File No. 73872

PLACE OF DEATH

County of Payette
City of Payette

CERTIFICATE OF DEATH

Registration District No. 4
Primary Registration District No. 1008 Local Registrar's No. 47
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Kathleen Geraldine Ladrow
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female
4. COLOR OR RACE white
5. Single, Married, Widowed, or Divorced (write the word.) single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Dec 5 - 1930
7. AGE Years Months Days 12. If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Baby.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Payette Idaho

PARENTS
10. NAME OF FATHER Dave Ladrow.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Oregon.
12. MAIDEN NAME OF MOTHER Ruby Bliss.
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Oregon.

14. Informant (Address) Dave Ladrow Payette Idaho.
15. Filed Dec 31, 1930 J. C. Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 19 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1930, to Dec 19, 1930
that I last saw her alive on Dec 19, 1930
and that death occurred, on the date stated above, at 5 P. m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pneumonia.
..... (duration) ..... yrs. ..... mos. 3 ds.
CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? none
(Signed) Merrill R. Fox, M. D.
Dec. 27, 1930 (Address) Payette Ida.

19. Place of Burial, Cremation, or Removal Payette Idaho. Date of Burial Dec 20 1930
20. Undertaker Glenn C Landon. Address Payette Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73873

PLACE OF DEATH
County of Bonneville
City of Payette

Registration District No. 4
Primary Registration District No. 1008
Local Registrar's No. 43
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Mary Alice Slaughter

(a) Residence. No. ..... St. .....
(Usual place of abode.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

RECEIVED JAN 17 1931
(If nonresident give city or town and State.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. Single, Married, Widowed, or Divorced (write the word.): single

6a. If married, widowed, or divorced
HUSBAND of (or) WIFE of .....

6. DATE OF BIRTH (month, day and year)

7. AGE — Years: 4 — Months: 11 — Days: 26 — If LESS than 1 day, ...hrs. or .....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country): California

PARENTS

10. NAME OF FATHER: Chas M. Slaughter
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Oklahoma
12. MAIDEN NAME OF MOTHER: Mary B Green
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Texas

14. Informant (Address): E M Slaughter Payette Idaho

15. Filed 1 Dec 1 1930 J C Woodward Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28, 1930, to Nov 28, 1930, that I last saw h— alive on, Nov 28, 1930, and that death occurred, on the date stated above, at 3 p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Peritonsilar abscess

.....(duration) ..... yrs. ..... mos. 7 ds

CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) J C Woodward M. D
Nov 30, 1930 (Address) Payette, Ida

19. Place of Burial, Cremation, or Removal: Payette - Idaho — Date of Burial: Nov 30 19 30

20. Undertaker: Glenn C Landon — Address: Payette. Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73888

Registration District No. 55
Primary Registration District No. 213
Local Registrar's No. 1

PLACE OF DEATH
County of Bear Lake
City of St. Charles

RECEIVED 1931

(No.) (If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Emma Mattson Stewart

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
female	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lawrence Stewart

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	1		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Charles, Idaho

PARENTS
10. NAME OF FATHER Ola Mattson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) near Dimersham — Sweden
12. MAIDEN NAME OF MOTHER Malmo — Sweden
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Josephine K. Anderstedt

14. Informant Lawrence Stewart
(Address)

15. Filed , 19 . Hannah J. Nelson Registrar

MEDICAL CERTIFICATE OF DEATH

47

16. DATE OF DEATH Sept (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7, 1930 to Sept 3, 1930
that I last saw her alive on Sept 2, 1930
and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows:
Cancer breast — left —
(duration) yrs. 7 mos. ds.
CONTRIBUTORY (Secondary) Chronic Myocarditis
(duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) C O Sugard, M. D.
9/4, 1930 (Address) Paris Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St. Charles Id	19
20. Undertaker	Address

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STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73897

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 308

2. FULL NAME Lester William Thomas

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 29 yrs. 8 mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie Anderson Thomas

6. DATE OF BIRTH (month, day and year) March 28 1853

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	7	28	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10. NAME OF FATHER John Thomas
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Wales
12. MAIDEN NAME OF MOTHER Margaret Hughes
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Wales

14. Informant Nellie Anderson Thomas
(Address) Kooskia Idaho

15. Filed Nov 27, 1930 J M Verbeek Kyers Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 26 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11, 1930, to Nov 26, 1930, that I last saw h[illegible] alive on Nov 11, 1930 and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J M Verbeek Kyers M. D.
Nov 27, 1930 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial 19
20. Undertaker	Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED FEB 26 1931

DO NOT WRITE IN THIS SPACE

State File No. 73912

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No.

Local Registrar's No. 73912

PLACE OF DEATH

County of Jerome

City of

(No. 129)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel O'Connor

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64			

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10. NAME OF FATHER Jeremiah O'Connor

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Hopkins

13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Kentucky

14. Informant Howard O'Connor
(Address) San Francisco Calif

15. Filed 2/26, 1931 Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 8 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Oct 9, 1930, that I last saw h[illegible] alive on Oct 7, 1930, and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
Myocarditis (duration) 2 yrs. mos. ds.

18. Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Chas F Chamberlee, M. D.

Feb 26, 1931 (Address) Jerome Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Jerome Cemetery	Oct 11 1930

20. Undertaker	Address
D R L Harrison	Jerome

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73914

PLACE OF DEATH

County of Jerome
City of

Registration District No. 18
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

2. FULL NAME Sarah Tipton

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year): Aug 15 - 1930

7. AGE: Years X; Months 2; Days 15; If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Jerome Idaho

PARENTS

10. NAME OF FATHER: J L Tipton
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Marshall N Carolina
12. MAIDEN NAME OF MOTHER: Jane Silver
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Bakersville N Carolina

14. Informant: J L Tipton
(Address): Jerome

15. Filed 2/26, 1931. Chas F Zeller Registrar

MEDICAL CERTIFICATE OF DEATH 113

16. DATE OF DEATH: Oct (Month) 30 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16, 1930, to Oct 30, 1930
that I last saw her alive on Oct 28, 1930
and that death occurred, on the date stated above, at 5 p m.
The CAUSE OF DEATH* was as follows:
Infection Diarrhoea
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary): Middle ear infection
(duration) yrs. mos. 14 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Wm F Schmershall, M. D.
Nov 12, 1930 (Address) Jerome

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Cemetery
Date of Burial: Oct 31 1930

20. Undertaker: D A L Henisbaw
Address: Jerome

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

RECEIVED FEB 19 1931

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 73873
Township or Village or
City Lewiston No. , at home St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Leo James Ft. Lapwai Indian Agency 162
(a) Residence. No. 1 Kimbell Court St., Ward. Lapwai, Idaho.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE 4/4 Nez Perce Indian
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) Dec. 15 1930
7 AGE Years Months Days 12 If LESS than 1 day, ---- hrs. or ---- min.
8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer
9 BIRTHPLACE (city or town) Lewiston
(State or country) Idaho

PARENTS
10 NAME OF FATHER Jonas James
11 BIRTHPLACE OF FATHER (city or town) Ahsahka
(State or country) Idaho
12 MAIDEN NAME OF MOTHER Ida Luton
13 BIRTHPLACE OF MOTHER (city or town) Pendleton
(State or country) Orgon

14 Informant Jonas James Father
(Address) Lewiston, Ida.
15 Filed 4/17, 1931 L. M. Maxwell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 27" 1930
17 I HEREBY CERTIFY, That I attended deceased from No attending, 19 to Physician, 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
Probably Malnutrition
Baby very small &
weak at birth
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) J. M. Lyle, M. D.
12/27, 1930 (Address) Lewiston, Ida

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Ahsahka, Ida.
DATE OF BURIAL 19
20 UNDERTAKER Brower-Wann Co
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2—200 d
V. S. No. 98

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 73995

PLACE OF DEATH

County of Bonner
City of Clagstone

Registration District No. 45
Primary Registration District No.
(No.)

Local Registrar's No. 3

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME David Gipson Grigg

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M.	Wh.	Married

5a. If married, widowed or divorced
HUSBAND of
(or) WIFE of Sarah Frances Grigg

6. DATE OF BIRTH (month, day and year) July 10 - 1857

7. AGE	Years	Months	Days	If LESS than 1 day,
	72	9	2	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) Greenville
(State or country) Ill

PARENTS

10. NAME OF FATHER Jessie R. Grigg
11. BIRTHPLACE OF FATHER (city or town)
(State or Country) N. Carolina
12. MAIDEN NAME OF MOTHER Sarah Rhea
13. BIRTHPLACE OF MOTHER (city or town)
(State or Country) Ill

14. Informant Sarah K. Grigg
(Address)

15. Filed Apr 11, 1930 A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH 12

16. DATE OF DEATH
4 (Month) 11 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
was called, but pt died before
that I last saw h alive on & arrived, 19
and that death occurred, on the date stated above, at 11:45 P m.
The CAUSE OF DEATH* was as follows:

Chronic passive Congestion
(duration) 3 yrs. 10 mos. 12 ds.
CONTRIBUTORY (Secondary) Heart leakage
(duration) 5 yrs. 2 mos. 15 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Fluid in abdomen
(Signed) Nelson Hersey, M. D.
Apr 12, 1930 (Address) Sprout Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Sprout Lake, Ida	19

20. Undertaker	Address
Cassidy	Rathdrum

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74100

PLACE OF DEATH
County of Kootenai
City of Spirit Lake

Registration District No. 45
Primary Registration District No.
(No. Spirit Lake Hospital)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 2

2. FULL NAME Robert J. Magee
(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 27 1870. Do not know date.

7. AGE	Years	Months	Days	If LESS than 1 day,
	59	10	10	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Panhandle Lumber Co.

9. BIRTHPLACE (city or town) Peterborough
(State or country) Ontario

PARENTS

10. NAME OF FATHER Do not know
11. BIRTHPLACE OF FATHER (city or town) Do not know
(State or Country)
12. MAIDEN NAME OF MOTHER " "
13. BIRTHPLACE OF MOTHER (city or town) "
(State or Country)

14. Informant Chas W. Temps
(Address) Spirit Lake, Idaho

15. Filed 3-10, 1930 A. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 7 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25- 1929, to Mch 7 1930
that I last saw him alive on March 7, 1930
and that death occurred, on the date stated above, at 9:30 P m.
The CAUSE OF DEATH* was as follows:

Secondary Anaemia
(duration) yrs. 4 mos. 5 ds.
CONTRIBUTORY (Secondary) Empyema of right chest
(duration) yrs. 4 mos. 5 ds.

18. Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Nov 5 1929
Was there an autopsy? No
What test confirmed diagnosis? Laboratory X-Ray
(Signed) Nelson L. Hersey, M. D.
3-9, 1930 (Address) Spirit Lake.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Greenwood Cemetery Spirit Lake	3-10 1930
20. Undertaker	Address
Cassedy Funeral Home	Pathdrum

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74101

PLACE OF DEATH

County of Kootenai
City of Spirit Lake.

Registration District No. 45
Primary Registration District No.
(No. Spirit Lake Hospital
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 4

2. FULL NAME Jess Lewis Thompson
(a) Residence. No. Hope Idaho St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lola Thompson.

6. DATE OF BIRTH (month, day and year) Sept -1880

7. AGE 49 Years Months 9 Days If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Barber.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10. NAME OF FATHER Wm H. Thompson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Missouri
12. MAIDEN NAME OF MOTHER Fanney Trapp.
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Missouri

14. Informant Mrs Jess L Thompson
(Address) Hope Idaho

15. Filed June 6, 1930. A C Spooner Registrar

MEDICAL CERTIFICATE OF DEATH 74a

16. DATE OF DEATH 6 (Month) 5 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd, 1930, to June 5, 1930.
that I last saw him alive on June 5, 1930.
and that death occurred, on the date stated above, at 11:55 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) High blood pressure

Questionable (duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? stroke occured along road. While walking
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Blood pressure and clinical findings
(Signed) Nelson Hussey, M. D.
June 7, 1930 (Address) Spirit Lake Id.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Greenwood Cemetery Spirit Lake
Date of Burial 6-8 1930

20. Undertaker Cassedy Funeral Home
Address Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

RECEIVED MAR 10 1930

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74102

PLACE OF DEATH
County of Kootenai
City of Spirit Lake.

Registration District No. 45
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 1

2. FULL NAME Julia A. Berglund

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred. 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of John A. Berglund

6. DATE OF BIRTH (month, day and year) March 23, 1854

7. AGE	Years	Months	Days	If LESS than 1 day,
	75	11	13	hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ashland Kentucky

PARENTS

10. NAME OF FATHER John Wilson
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Byrd County - Kentucky
12. MAIDEN NAME OF MOTHER Do not know
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) " "

14. Informant Victor Berglund
(Address) Spirit Lake Ida.

15. Filed Mch 9, 1930. A. L. Spooner Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3- (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-5-30, 1930, to 3-6-30, 1930, that I last saw h alive on 3-6-30, 1930, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal-Arteriosclerosis

(duration) 1 yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Colicystitis.

(duration) yrs. 6 mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis Clinically

(Signed) Nelson Hersey M. D.
3-9, 1930. (Address) Spirit Lake

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Riverwood Cemetery Spirit Lake Ida — Date of Burial: 3-10 1930

20. Undertaker: Easley Funeral Home — Address: Rathdrum

RECEIVED

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

74140

1 PLACE OF DEATH

County Idaho State Idaho Registered No.

Township Nez Perce Reservation or Village Stites or

City Ft. Lapwai Indian Agency No. At home St., Ward

Lapwai, Idaho.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucele White

(a) Residence. No. Stites, Ida St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

205 b

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	4/4 Nez Perce Indian	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Stites
(State or country) Idaho

PARENTS

10 NAME OF FATHER Joseph White

11 BIRTHPLACE OF FATHER (city or town) Juliaetta
(State or country) Idaho

12 MAIDEN NAME OF MOTHER Isabelle George

13 BIRTHPLACE OF MOTHER (city or town) Pendleton
(State or country) Oregon

14 Informant C. H. Bryan M.D.
(Address) Kamiah, Ida.

15 Filed 1/20/1931 L. W. Maxwell
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from No medical attendance since hour of birth, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Not Known

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (SECONDARY) ✓

(duration) — yrs. — mos. — ds.

18 Where was disease contracted ✓
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. H. Bryan, M. D.

1/16/1931 (Address) Kamiah, Ida.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Stites Cemetery	Dec. 27 1930
20 UNDERTAKER	ADDRESS
None	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 96

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74159

PLACE OF DEATH
County of Latah
City of Harvard

Registration District No. 65
Primary Registration District No. 2145
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. **FULL NAME** Mary Fredrica Gallup

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: L. H. Gallup

6. DATE OF BIRTH (month, day and year): June 23, 1900

7. AGE: Years 30 | Months 6 | Days 5 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): North Dakota

PARENTS

10. NAME OF FATHER: Edward Pimmer
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Barber
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Not Known

14. Informant: L. H. Gallup
(Address): Harvard Ida

15. Filed Dec. 29, 1930. J. Jr. Thompson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓, 19..., to ✓, 19...
that I last saw her alive on Not Seen., 19...
and that death occurred, on the date stated above, at 5:30 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Died suddenly.
Chronic valvular disease of heart.
(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary): Not Known
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? ✓
(Signed) J. Jr. Thompson, M. D.
Dec. 29, 1930 (Address) Potlatch

19. Place of Burial, Cremation, or Removal: Palouse Prairie. Date of Burial: Jan 1 1931
20. Undertaker: E. Anderson Address: Clarkston Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74171

PLACE OF DEATH
County of Bannock
City of Grace

Registration District No. 84
Primary Registration District No. 2161
(No.)

Local Registrar's No. 204

(If death occurred in a hospital or institution give its name instead instead of street and number.)

2. FULL NAME Beverly Bennett

(a) Residence. No. St.
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Aug 23, 1930

7 AGE: Years 0 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Grace, Idaho

PARENTS

10 NAME OF FATHER: Orin I Bennett
11 BIRTHPLACE OF FATHER (city or town) (State or country): Lago Idaho
12 MAIDEN NAME OF MOTHER: Lila Harwood
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Granite Utah

14 Informant: Father
(Address)

15 Filed Feb 28, 1931 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec (Month) 27 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1930, to Dec 27, 1930
that I last saw her alive on Dec 23, 1930
and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia.
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bad heart
(duration) yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) [illegible], M. D.
12-26, 1930 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

RECEIVED MAR 3 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 74179

Registration District No. 84

Primary Registration District No. 2161

(No.)

Local Registrar's No. 208

PLACE OF DEATH

County of Bannock

City of Grace

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Joan Peterson

(a) Residence. No. 1619 St.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year): Sept 21-30

7 AGE: Years 0 Months 0 Days 0 If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Grace Ida

PARENTS

10 NAME OF FATHER: Donald Thurman Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bench Idaho

12 MAIDEN NAME OF MOTHER: Charlotte Vianna Lasley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): American Falls, Idaho

14 Informant: Father
(Address): Grace Ida

15 Filed Feb 28, 1931 Mrs G. G Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Sept (Month) 22 (Day) 30 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1930, to Sept 22, 1930, that I last saw h[illegible] alive on Sept 21, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Joseph E Otte M. D.

Sept 23, 1931 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH 84

DO NOT WRITE IN THIS SPACE
State File No. 74187

Local Registrar's No. 285

PLACE OF DEATH
County of Bannock
City of Grace
Registration District No.
Primary Registration District No. 2161
(No. 709 (If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME Minnie Ann Whitehead Johnson

(a) Residence. No. St.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nels Johnson

6 DATE OF BIRTH (month, day and year): Mar 15 1874

7 AGE: Years 56 | Months 9 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ogden Utah

PARENTS
10 NAME OF FATHER: Francis Whitehead
11 BIRTHPLACE OF FATHER (city or town) (State or country): England
12 MAIDEN NAME OF MOTHER: Jacoba Jane Robinson
13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Husband
(Address): Grace Idaho

15 Filed Jan 28, 1931 Mrs. G. G. Fitz Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 12 (Month) 30 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1-1- 1928, to 12-30 1930, that I last saw her alive on 12-2- 1930, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:
Apoplexy
(duration) 15 yrs. mos. ds.
CONTRIBUTORY (Secondary) High blood pres-
-sure (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Examination
(Signed) Joseph E Otte M. D.
12-30 1930 (Address) Grace Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal | Date of Burial 19

20. Undertaker | Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Ft.Hall Jurisdiction, Current, Complete Dec. 1930

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 74211

PLACE OF DEATH

County of Ft.Hall Reservation, Idaho.

City of

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194 Local Registrar's No. 59

(No. Out at Ranch.)

(If death occurred in a hospital or institution, give its name instead of street and number.)

11 b

2. **FULL NAME** Gladys Bache

(a) Residence. No. --- - - - - - St.

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. 4 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Shoshone Ind. 4/4

5. Single, Married, Widowed, or Divorced (write the word.): Singhle

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6. DATE OF BIRTH (month, day and year)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
0	0	4	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER William Bache

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Lemhi Reservation

12. MAIDEN NAME OF MOTHER Lizzie Tindahay

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant (Address) Mar 29 William Burton Ft.Hall,Idaho

15. Filed Mar. 29. 1931 Mrs Walter E. Patrick Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 14, 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor Attending, 19..., to ..., 19...

that I last saw h... alive on ..., 19...

and that death occurred, on the date stated above, at 10A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Flu.

(duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18. Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ---

(Signed) Henry R. Wheeler, M. D.

..., 19... (Address) Ft.Hall,Ida

19. Place of Burial, ~~Cremation~~, or ~~Removal~~: Butte Cemetery, Ft.Hall Reservation

Date of Burial: Dec.15,31 19

20. Undertaker: Brown & Eldredge,Blackfoot,Ida

Address

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

Ft. Hall Jurisdiction, Current- Complete, Dec. 1930

RECEIVED DEC 4 19

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74223

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Ft. Hall Reservation
City of Idaho.
Fort Hall Hospital.

Registration District No. 121
Primary Registration District No. 2194
(No. Ft. Hall Agency Hospital.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 33

2. FULL NAME Titerah Pocatello

(a) Residence. No. ----- St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Wooda Pocatello

6. DATE OF BIRTH (month, day and year) ---- 1850

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Washakie, Utah

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Tisso
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Washakie, Utah.

14. Informant Sam Panguich
(Address) Ft. Hall, Idaho

15. Filed March 29, 1930 Walter E. Petrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 11, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1930, to Dec. 11, 1930
that I last saw her alive on Dec. 11, 1930
and that death occurred, on the date stated above, at 1:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Flu.

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) ---
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? ---
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical signs.

(Signed) Henry R. Wheeler M. D.
---- 19 (Address) Ft. Hall, Ida.

19. Place of Burial, Cremation, or Removal: Portneuf, Cem. Ft. Hall Reservation — Date of Burial: 12/13/30 19

20. Undertaker: Shoemaker & Beasley, Pocatello Idaho. — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Ft.Hall Jurisdiction, Current Complete Dec. 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74224

PLACE OF DEATH

CERTIFICATE OF DEATH

County of Ft.Hall Reservation,
City of Idaho.
Registration District No. 121
Primary Registration District No. 2197
Local Registrar's No. 34
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Susie Ocean

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	Shoshone Ind. 4/4	Married

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Chris Ocean

6. DATE OF BIRTH (month, day and year) ---- 1860

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	--	--	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Poo-at-a-zee

13. BIRTHPLACE OF MOTHER (city or town) (State or County) virginia, Idaho.

14. Informant Chris Ocean
(Address) Ft.Hall, Idaho

15. Filed March 29, 1930 Mrs Walter E. Patrice Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 17, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from
Dec. 11, 1930, to Dec. 17, 19..
that I last saw her alive on Dec. 17, 1930, 19..
and that death occurred, on the date stated above, at 7:p m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Flu.

(duration) yrs. mo6 ds.

CONTRIBUTORY (Secondary) Pneumonia- broncho

(duration) yrs. mo6 ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Phys. Signs

(Signed) Henry R. Wheeler, M. D.
---- , 19.. (Address) Ft.Hall, Ida

19. Place of Burial, Cremation, or Removal: Epischopal Mission, Ft.Hall, Idaho, — Date of Burial: 12/21/30 19..

20. Undertaker: Agency Carpenter, Ft.Hall, Id — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

Ft.Hall Jurisdiction, Current Complete Dec. 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74225

PLACE OF DEATH
County of Ft.Hall Reservation, CERTIFICATE OF DEATH
City of Idaho. Registration District No. 121
Primary Registration District No. 2195 Local Registrar's No. 35
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Daniel Punkin

(a) Residence. No. ------ St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. 1 yrs. 9 mos. 3 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of -----

6. DATE OF BIRTH (month, day and year) Apr. 27, 1929

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9	3	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown
12. MAIDEN NAME OF MOTHER Clara Punkin
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant Clara Punkin
(Address) Ft.Hall Reservation

15. Filed March 29 1931 Mrs Walter E. Petrie Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec.30, 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19..., to ..., 19...
that I last saw h... alive on ..., 19...
and that death occurred, on the date stated above, at 7:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Flu.

(duration) ...yrs. ...mos. 6 ...ds.

CONTRIBUTORY (Secondary) Pneumonia, Bronchial

(duration) ...yrs. ...mos. 5 ...ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Signs
(Signed) Henry R. Wheeler M. D.
----- 19... (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal: Mt.Putman Cemetery, Ft.Hall Reservation, — Date of Burial: I/I/31 19

20. Undertaker: Agency Carpenter, Ft.Hall, Id — Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED APR 11 1931

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
74235

1. PLACE OF DEATH

County Umatilla State Oregon Registered No.

Township Off Res. or Village or

City Pendleton No. St. Anthony's Hospital St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Joseph Louis

(a) Residence: No. Umatilla Ore. St., Ward. Fort 188C
(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Full blood Indian

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married 689

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cecelia Thompson

6. DATE OF BIRTH (month, day, and year): June 9, 1895

7. AGE: Years 35 | Months 6 | Days 16 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc: Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc: Farm

10. Date deceased last worked at this occupation (month and year): 1

11. Total time (years) spent in this occupation: 10

12. BIRTHPLACE (city or town) (State or country): Mission De Smet Ida.

FATHER

13. NAME: Joe Louie

14. BIRTHPLACE (city or town) (State or country): Mission De Smet Ida.

MOTHER

15. MAIDEN NAME: Louisa Thomas

16. BIRTHPLACE (city or town) (State or country): Mission De Smet Ida.

17. INFORMANT: ? (Address)

18. BURIAL, CREMATION, OR REMOVAL
Place Date , 19

19. UNDERTAKER (Address)

20. FILED , 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year): Dec. 25, 1930

22. I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1930 to Dec 25, 1930

I last saw him alive on Dec 25, 1930 death is said to have occurred on the date stated above, at 8:30 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Intracranial Injury	Dec 25
Struck by auto	"
Other contributory causes of importance: Fractured Maxilla	"

Name of operation: None Date of:

What test confirmed diagnosis? Exam Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ? Date of injury 12-25-1930

Where did injury occur? Near Pendleton, Ore. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Public Highway

Manner of injury Struck by Auto

Nature of injury Intracranial injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) J. L. McBee, M. D.

(Address) Pendleton, Ore

c11—3184

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—2091
V. S. No. 98

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

74411

1. PLACE OF DEATH

County Kootenai State Idaho Registered No. _____

Township Coeur d' Alene Reservation Village _____ or

City Worley, R. F. D. No. Not in hospital St., _____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred _____ yrs. 5 mos. 18 ds. How long in U. S. if of foreign birth? _____ yrs. _____ mos. _____ ds.

101B

2. FULL NAME Conard Anasta Cherrapkin

(a) Residence: No. Worley, Idaho St., _____ Ward. _____

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Full Blood Indian	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6. DATE OF BIRTH (month, day, and year)

7. AGE Years	Months	Days	If LESS than 1 day, _____ hrs. or _____ min.
	5	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper,** etc: None

9. Industry or business in which work was done, as **silk mill, saw mill, bank,** etc: None

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (city or town) Plummer, Ida. (State or country) RFD #1.

FATHER

13. NAME Joe Cherrapkin

14. BIRTHPLACE (city or town) Mottern Valley (State or country) near Plummer.

MOTHER

15. MAIDEN NAME Ann Antelope

16. BIRTHPLACE (city or town) Mottern Valley (State or country) near Plummer

17. INFORMANT Joseph Cherrapkin (Address) Plummer, Ida.

18. BURIAL, CREMATION, OR REMOVAL Place _____ Date _____, 19____

19. UNDERTAKER H. G. Jaeger. (Address) Plummer, Ida.

20. FILED _____, 19____ _____ *Registrar.*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Feb. 25, 1930

22. I HEREBY CERTIFY, That I attended deceased from did not see the child at any time, 19____ to _____, 19____

I last saw h_____ alive on _____, 19____; death is said to have occurred on the date stated above, at 8 p. m.

The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Pneumonia	
Other **contributory causes** of importance:	

Name of operation None Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (**violence**) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in **industry**, in **home**, or in **public place**.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. J. Harrington, M. D.

(Address) Worley, Idaho.

e11—3184

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—2097
V. S. No. 98

FORM V. S. No. 5-25 M. 1-19.

RECEIVED

CERTIFICATE OF DEATH

1931 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 14488
Registered No. 8

1. PLACE OF DEATH
County of Idaho
City of Lucile
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Addison Sewell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: May (Month) 25 (Day) 1857 (Year)

7. AGE: 73 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Marion County, Oregon

10. NAME OF FATHER David Sewell

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Elizabeth Marrisane

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ward Sewell
(Address) Lucile, Idaho

15. Filed April 1 1931 B. Chipman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1930, to Aug. 19 1930, that I last saw him alive on Aug 17 1930, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Paresmonia & gall Bladder
(Duration) ..... Yrs. 15 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wesley F. Orr M. D.
8/20 1930 (Address) Cottonwood, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: John Day Cemetery — DATE OF BURIAL: Aug. 21 1930

20. UNDERTAKER Near Lucile — ADDRESS Vassar, Mud. Co. Lewiston

RECEIVED [illegible] 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74537

CERTIFICATE OF DEATH

PLACE OF DEATH
County of Clearwater
City of Orofino
Registration District No. .....
Primary Registration District No. 2187
Local Registrar's No. 16
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Wolf Gain Winters

(a) Residence. No. Nelson Hospital St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M	White	Widowed

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 80			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) Germany
(State or country)

PARENTS
10. NAME OF FATHER ?
11. BIRTHPLACE OF FATHER (city or town) ?
(State or Country)
12. MAIDEN NAME OF MOTHER ?
13. BIRTHPLACE OF MOTHER (city or town) ?
(State or County)

14. Informant Nelson Hospital Orofino
(Address)

15. Filed Mar 4, 1931 W. A. Shaw Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 3 (Day), 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9, 1930, to Oct 13, 1930
that I last saw him alive on Oct. 13, 1930
and that death occurred, on the date stated above, at 5.30 A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Arterial sclerosis

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical.

(Signed) C. J. Hoffman, M. D.
3/7/31, 19.... (Address) Orofino, Ida.

19. Place of Burial, Cremation, or Removal	Date of Burial
Orofino Ida	Mar 14 1931

20. Undertaker W. A. Shaw
Address Orofino

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED MAY 18 1931 74636

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74636

PLACE OF DEATH
County of Idaho
City of Kooskia

Registration District No. 106
Primary Registration District No. 2184
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. Begin May no.

2. FULL NAME James Warrell

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Rebecca Warrell

6. DATE OF BIRTH (month, day and year): May 25 - 1836

7. AGE: Years ~~93~~ 94 | Months 5 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired -- butcher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): England.

PARENTS

10. NAME OF FATHER: William Warrell
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Ann —
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): England.

14. Informant: Frederic William Warrell
(Address)

15. Filed May 14, 1931. J M Verberkmoes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:
No medical attendant -
Had an attack of ileo colitis.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) J M Verberkmoes, M. D.
Nov. 8, 1930 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kooskia Cemetery | Date of Burial: Nov 8 1930

20. Undertaker: Geo Trenary | Address: Kooskia - Idaho

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED ADD 07 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74855

PLACE OF DEATH
County of Idaho
City of Kamiah

Registration District No. 41
Primary Registration District No. 2127 Local Registrar's No. 24
(No. ..... If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME [illegible] 31

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. Single, Married, Widowed, or Divorced (write the word.): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) Nov. 17-1902

7. AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Driver
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Kamiah

PARENTS

10. NAME OF FATHER: Daniel
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Kamiah Idaho
12. MAIDEN NAME OF MOTHER: Ellen Wa[illegible]
13. BIRTHPLACE OF MOTHER (city or town) (State or County): [illegible] Idaho

14. Informant (Address)

15. Filed 11-20-31 J. W. Robertson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 18 (Month) (Day) 19 31 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 19 31, to Nov. 19 31
that I last saw him alive on Nov. 17 19 31
and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) [illegible] M. D.
Nov. 19, 1931 (Address) Kamiah

19. Place of Burial, Cremation, or Removal: Kamiah #2 — Date of Burial: 11-21-31

20. Undertaker: Kamiah Funeral Home — Address: Kamiah Ida.

RECEIVED APR 27 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 74894

PLACE OF DEATH

County of Lewis
City of Kamiah

CERTIFICATE OF DEATH

Registration District No. 49
Primary Registration District No. 2127 Local Registrar's No. 26
(No.) 129
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Carrie S. Short

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W.
5. Single, Married, Widowed, or Divorced (write the word.) married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of W. C. Short

6. DATE OF BIRTH (month, day and year) Apr 28 1860

7. AGE — Years 70 Months 7 Days 17 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Silverton Oregon

PARENTS

10. NAME OF FATHER Cyrus Miner
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Annie Bowman
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ill

14. Informant (Address) Mrs J. T. Wayne Clearwater Idaho

15. Filed 12/16, 1930 W. Roberts Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 15 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1928 to Chronic, 19
that I last saw her alive on Dec. 10th 1930
and that death occurred, on the date stated above, at 11:30 a.m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Chronic Interst. Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Microscopic
(Signed) C. S. Burnham, M. D.
12/16, 1930 (Address) Kamiah

19. Place of Burial, Cremation, or Removal Kamiah Dock
Date of Burial 12/17 1930

20. Undertaker [illegible] Address Kamiah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 27 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74895

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 49
Primary Registration District No. 2127 Local Registrar's No. 27
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

90

2. FULL NAME Everett Sink
(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) 6-27-1911

7. AGE Years 19 Months 6 Days 2 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) High School
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ferdinand Idaho

PARENTS
10. NAME OF FATHER Chas Sink
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas City Mo
12. MAIDEN NAME OF MOTHER Davidson
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Dayton Wash

14. Informant (Address) J Robertson

15. Filed 12/29, 1930 W Robertson Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) 28 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November, 1929, to 12/28, 1930
that I last saw him alive on 12/27, 1930
and that death occurred, on the date stated above, at 8-a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
Broken Compensation

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Myo Carditis
(duration) yrs. 1 mos. ds.

18. Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? None
(Signed) A. L. Bryan M. D.
12/29, 1930 (Address) Kamiah

19. Place of Burial, ~~Cremation, or~~ Removal Winona
Date of Burial 12/30 1930

20. Undertaker [illegible]
Address [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED APR 27 1931

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74899

PLACE OF DEATH
County of Lewis
City of Kamiah

Registration District No. 47
Primary Registration District No. 2127
Local Registrar's No. 22

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

119

2. FULL NAME Donald Wesley Doty

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) S

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day and year) 9-5-28

7. AGE ~~2~~ Years 2 Months 0 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winona Ida

PARENTS

10. NAME OF FATHER Chester O Doty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Winona Ida
12. MAIDEN NAME OF MOTHER Dove
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alberta - Can

14. Informant Chester O. Doty
(Address)

15. Filed 9/30/31, 19 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15th, 1930, to Ahaus, 19..., that I last saw him alive on Sept. 28, 1931, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Anthrax Colitis

..... (duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) A S Bryan, M. D.
Sept. 28, 1930 (Address) Kamiah

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Kamiah Dock — Date of Burial: 9-30-31

20. Undertaker: J W Robertson — Address: Kamiah

RECEIVED APR 27 1931

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 74903

PLACE OF DEATH
County of Lewis
City of

Registration District No. 49
Primary Registration District No. 2127
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 23

16 ✓

2. FULL NAME Lloyd Dale Doty

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. Single, Married, Widowed, or Divorced (write the word) Child

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Inf

6. DATE OF BIRTH (month, day and year) 9-20-30

7. AGE Years Months Days 20 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED ✓
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) ✓
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Winona Ida

PARENTS
10. NAME OF FATHER Chester O Doty
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Winona Idaho
12. MAIDEN NAME OF MOTHER Bernice Dove
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Alberta Can

14. Informant Chester O Doty
(Address) Kamiah Ida

15. Filed 10/12 31 J W Robertson Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 1 (Month) 11 (Day) 30 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2nd, 19 , to April, 19
that I last saw him alive on Oct 9th, 19
and that death occurred, on the date stated above, at 6 p m.
The CAUSE OF DEATH* was as follows:
Calitis
(duration) yrs. mos. 14 ds.
CONTRIBUTORY (Secondary) Infancy
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) [illegible], M. D.
Oct. 2nd, 1930 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal Kamiah Ida
Date of Burial 10/12 1931

20. Undertaker J W Robertson
Address Kamiah

RECEIVED JUN 5 1931

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE

State File No. 75202

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Idaho

City of Wenona

Registration District No. 103

Primary Registration District No. 2181

Local Registrar's No. 14

(No. 201)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Ann. Miller

(a) Residence. No. ..... St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Female	White	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lee Miller

6. DATE OF BIRTH (month, day and year) 1-21-1842

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	9	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (city or town) (State or country) Hampshire England

PARENTS

10. NAME OF FATHER Wm Brunswick

11. BIRTHPLACE OF FATHER (city or town) (State or Country) England

12. MAIDEN NAME OF MOTHER Pricilla Will

13. BIRTHPLACE OF MOTHER (city or town) (State or County) England

14. Informant (Address) B A Miller Wenona Ida

15. Filed ....., 19..... Registrar. .....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 6 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18, 1930, to Nov - 6, 1930

that I last saw her alive on Oct 28, 1930

and that death occurred, on the date stated above, at ..... m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Fractured Hip.

..... (duration) ..... yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Wesley F. Orr, M. D.

Nov 6, 1930 (Address) Collins Wenona Idaho

19. Place of Burial, Cremation, or Removal	Date of Burial
Grangeville Ida	Nov. 7 1931
20. Undertaker Hancock Und Co.	Address Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 75213

PLACE OF DEATH
County of Idaho
City of Grangeville

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 17
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

49

2. FULL NAME Melinda Bell Earp
(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word.) Married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Earp
6. DATE OF BIRTH (month, day and year) Jan 3 1863
7. AGE Years 67 Months 9 Days 30 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Arkansas

PARENTS
10. NAME OF FATHER Kalvin Seay
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Georgia
12. MAIDEN NAME OF MOTHER Thomison
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Georgia

14. Informant (Address) Grangeville Idaho Jos E. Earp
15. Filed 6-2, 1931 B. Chapman Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 31 (Day), 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 4, 1930, to Oct 31, 1930
that I last saw her alive on Oct 25, 1930
and that death occurred, on the date stated above, at ..... m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Carcinoma of Gall bladder
..... (duration) 2 yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) —
..... (duration) ..... yrs. ..... mos. ..... ds.
18. Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of Aug 4-30
Was there an autopsy? No
What test confirmed diagnosis? Pathological report.
(Signed) Wesley F. Orr, M. D.
Oct, 1931 (Address) Cottonwood

19. Place of Burial, Cremation, or Removal Grangeville Ida. Date of Burial Nov. 2 1931
20. Undertaker Duncan Mnd. Co. Address Grangeville Ida.

Ft.Hall Jurisdiction. Current (Delayed) Complete June 1930

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 75659

PLACE OF DEATH
County of Ft.Hall Reservation.
City of At Ranch

CERTIFICATE OF DEATH
Registration District No. 121
Primary Registration District No. 2194-R Local Registrar's No. 113
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Harry Antelope.

(a) Residence. No. - - - - - - St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. -- yrs. --mos. --ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	Shoshone Ind. 4/4	Single

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of - - - - - - - - -

6. DATE OF BIRTH (month, day and year) May 26, 1930

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	I	2	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Ft.Hall Reservation

PARENTS

10. NAME OF FATHER Sam Antelope.
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Nevada
12. MAIDEN NAME OF MOTHER Lucy Shay
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Ft.Hall Reservation

14. Informant (Address) Sam Antelope. Ft.Hall, Idaho.

15. Filed July 3, 19 31 Mrs Walter E Farr Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 28, 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor attending, 19 , 19 to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 9:P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Pneumonia- broncho

(duration) yrs. mos. 3 ds.

CONTRIBUTORY - - - - -
(Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death? At Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? History of case
(Signed) Henry [illegible] M.D.
- - - -, 19 (Address) Ft. Hall, Ida

19. Place of Burial, Cremation, or Removal	Date of Burial
Bannock Cemetery, Ft.Hall Reservation	7/30/30 19
20. Undertaker Sam Antelope. Ft.Hall, Idaho	Address

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JUL 6

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 75137

Copied July 12th 1931

PLACE OF DEATH

County of Teton

City of Driggs

Registration District No. 77

Primary Registration District No. 3176

Local Registrar's No. 14

(No. ....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Caroline K. Nielson

(a) Residence. No. .... St. ....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
F	W	Married

5a. If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of James Nielson

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	6	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Preston, Idaho

PARENTS

10. NAME OF FATHER Hans Kofoed

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Thora Anderson

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Denmark

14. Informant (Address) Jas. Nielson Driggs, Idaho

15. Filed 7-1-, 1931 Martha Marker Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 (Month) - 7 (Day) - 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1930, to Dec. 7, 1930, that I last saw her alive on Dec. 7, 1930, and that death occurred, on the date stated above, at 3:00 A. m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia and Shock

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Abdominal Adhesions Following Colostomy for Intestinal Obstruction

(duration) 2 yrs. ....mos. ....ds.

18. Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) R. T. Cutcheon, M. D.

12/9, 1930 (Address) Driggs, Idaho.

19. Place of Burial, Cremation, or Removal: Cache Cemetery — Date of Burial: 12-10-1930

20. Undertaker: Vern J. Kelly — Address: Rexburg, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING
PHYSICIAN

RECEIVED SEP 21 1931

76066

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 76066

Registration District No. 103
Primary Registration District No. 2181
Local Registrar's No. 31

PLACE OF DEATH
County of Idaho
City of Grangeville
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

182

2. FULL NAME George Hunning.

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Not Known

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about 56.				

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Prospector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town) (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant Chas Kunzie
(Address) Grangeville Ida.

15. Filed 9-18-, 1931 B. Chipman Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: about June (Month) 16- (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:
Drowned - Clearwater River near Harpster Ida.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) A A Hancock Coroner M. D.
9-16-, 1931 (Address) Grangeville

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Near Harpster Ida. — Date of Burial: 6-25- 1931

20. Undertaker: Hancock Mort. Co. — Address: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED AUG 18 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 76196

PLACE OF DEATH

County of Bonneville
City of Riverdale

CERTIFICATE OF DEATH

Registration District No. 73
Primary Registration District No. 21 V-0
Local Registrar's No. 149
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Verner Dean Baldwin
(a) Residence. No. ..... St. Riverdale, Ida.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Single
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day and year) Mar. 28, 1930
7. AGE Years Months 4 Days 21 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9. BIRTHPLACE (city or town) (State or country) Riverdale Ida.

PARENTS
10. NAME OF FATHER Harry A. Baldwin
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Kansas
12. MAIDEN NAME OF MOTHER Florence Backlund
13. BIRTHPLACE OF MOTHER (city or town) (State or County) Riverdale Ida.

14. Informant (Address) Florence Backlund Riverdale Ida.
15. Filed Aug 24 1930 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 18 (Day) 1930 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 8-18, 1930, to 8-18, 1930
that I last saw him alive on 8-18, 1930
and that death occurred, on the date stated above, at 11 P m.
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows: Acute Obstruction of Bowell.
(duration) yrs. 6 hours mos. ds.
CONTRIBUTORY (Secondary) Acute intestinal Indigestion
(duration) yrs. mos. 2 ds.
18. Where was disease contracted if not at place of death? at home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Edwin Cutler, M. D.
8-19, 1930 (Address) Shelley Ida.

19. Place of Burial, Cremation, or Removal New Sweden — Date of Burial Aug. 24 1930
20. Undertaker Jack A. Wood — Address Idaho Falls

RECEIVED SEP 11 1931

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 76280
Registered No. 92

1. PLACE OF DEATH. Registration District No. 6
County of Ca Kem- Primary Registration District No. 2005
City of Emmett Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Baby Mc Cluskey -

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Infant

6. DATE OF BIRTH: July (Month) 26 (Day) 1930 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds. IF LESS than 1 day how many 20 minutes hrs. or 20 min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Emmett Idaho

10. NAME OF FATHER Lawrence M McCluskey

11. BIRTHPLACE OF FATHER (State or Country) Grand Falls New Brunswick

12. MAIDEN NAME OF MOTHER ~~Wife~~ Madeleine Muller

13. BIRTHPLACE OF MOTHER (State or Country) Buffalo N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. M. McCluskey
(Address) Emmett Idaho

15.
Filed 8-12-1931 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1930 (Year) 1619

17. I HEREBY CERTIFY, That I attended deceased from 7-26-1930, to 7-26-1930 that I last saw her alive on 7-26-1930 and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Premature infant

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
8-8-1931 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 8-9-1931

20. UNDERTAKER: John M. Ross & Valley — ADDRESS: Caldwell Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

RECEIVED NOV 30 1931

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 77371

PLACE OF DEATH

County of Twin Falls County

City of Twin Falls Idaho

CERTIFICATE OF DEATH

Registration District No. 18

Primary Registration District No. ..... Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

57

2. **FULL NAME** Jessie T. Houston,

(a) Residence. No. Route 3. Addison Ave. St. .....
(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) May 28, 1882

7. AGE: 49 Years | Months: 5 | Days: 17 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Colorado

PARENTS

10. NAME OF FATHER David Lee Houston

11. BIRTHPLACE OF FATHER (city or town) (State or Country) Scottland

12. MAIDEN NAME OF MOTHER Cary V. Brookbond

13. BIRTHPLACE OF MOTHER (city or town) (State or County) Indiana

14. Informant (Address) F. B. Houston / Jerome

15. Filed 11/27, 1931 Chas F. Zeller Jme Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 15th (Day), 1931 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12th, 1931, to Nov 15th, 1931
that I last saw him alive on Nov 13th, 1931
and that death occurred, on the date stated above, at A m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Diabetes Mel.

..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acidosis

..... (duration) ..... yrs. 1 mos. ..... ds.

18. Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Blood Sugar Exam
(Signed) Duncan L. Alexander M. D.
1176-31, 19..... (Address) Twin Falls Ida

19. Place of Burial, Cremation, or Removal: Jerome Cemetery | Date of Burial: Nov. 17 1931

20. Undertaker: A. L. Hrisson | Address: Jerome / Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

RECEIVED JAN 4 1932

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRI

State File No. 1

Copy

PLACE OF DEATH

County of Twin Falls

City of Twin Falls

Registration District No. 37

Primary Registration District No. 2085

(No. Twin Falls Co Hospital)

(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No. 68

117

2. FULL NAME Lee Sabola

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Spanish

5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day and year) February 22nd 1902

7. AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	1	26	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Sheepherder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Vallentine Baringa

9. BIRTHPLACE (city or town) (State or country): Spain

PARENTS

10. NAME OF FATHER: Juan Baliste Sabola

11. BIRTHPLACE OF FATHER (city or town) (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Francisca Kobega

13. BIRTHPLACE OF MOTHER (city or town) (State or Country)

14. Informant: Frank Sabola
(Address) Twin Falls Idaho

15. Filed 5-6, 1930. Elizabeth J. Smith, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18th (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 18, 1930 that I last saw him alive on April 18th, 1930 and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis chronic & acute exacerbation - Retrocecal (gangrenous) attached to duodenum last exacerbation (duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia ++++

..... (duration) ..... yrs. ..... mos. 3 ds.

18. Where was disease contracted if not at place of death? Twin Falls Co

Did an operation precede death? yes Date of April 17-30

Was there an autopsy? no

What test confirmed diagnosis? Operation & Pathologist

(Signed) Duncan L. Alexander, M. D.

4/19, 1930 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Twin Falls Idaho — Date of Burial: April 21st 1931

20. Undertaker: White Mortuary — Address: Twin Falls Ida

WRITE PLAINLY, WITH INFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

RECEIVED JUL 7 1932

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State File No. 79620

Registration District No. 19 F

Primary Registration District No. 2015

Local Registrar's No. 28

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merrill L. Goff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (~~Write the word~~)
6. DATE OF BIRTH: May (Month) 30 (Day) 1907 (Year)
7. AGE: 23 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF Father: Charles Goff
11. BIRTHPLACE OF FATHER (State or Country) Missouri
12. MAIDEN NAME OF MOTHER: Edna Renfro
13. BIRTHPLACE OF MOTHER (State or Country) Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edna Goff
(Address) Rupert Idaho
15.
Filed 7-5- 1932 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1930, to Oct 22 1930, that I last saw him alive on Oct 22 1930, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....
.....
(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19 ..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Oct 25 1930

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED OCT 3 1932

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 80737

PLACE OF DEATH
County of Nez Perce
City of Gifford

Registration District No. 92
Primary Registration District No. 2170
Local Registrar's No.

(No.) 205b
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Lewis Edward Harrington

(a) Residence. No. Culdesac Idaho St.
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. Single, Married, Widowed, or Divorced (write the word) Married

5a. If maried, widowed, or divorced HUSBAND of (or) WIFE of Clara Harrington

6. DATE OF BIRTH (month, day, and year) Mar - 6 - 1860

7. AGE Years 70 Months — Days — If LESS than 1 day, hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Retired
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Illinois

FATHER
13. NAME Morris Harrington
14. BIRTHPLACE (city or town) (State or country) Illinois

MOTHER
15. MAIDEN NAME Helen Conneley
16. BIRTHPLACE (city or town) (State or country) Illinois

17. INFORMENT (Address) Clara Harrington Culdesac Ida

18. BURIAL, CREMATION, OR REMOVAL Place Gifford Idaho Date 9/11, 1932

19. UNDERTAKER (Address) Brower - Warren Co. Lewiston Idaho

20. FILED 8-24, 1932 E. E. Watts Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Aug - 15 - 30 1930

22. I HEREBY CERTIFY, That I attended deceased from ....., 193...., to ....., 193....

I last saw h.....alive on ....., 193.....: death is said to have occurred on the date stated above, at .....m.

The principal cause of death and related causes of importance were as follows:

Cause unknown
Suffering with heart trouble, disappeared & found in woods
two years afterwards.

Other contributory causes of importance

Date of onset

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to exter'l causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 193..

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) C. M. Brower, M.D.
(Address) Lewiston, Idaho.

N. B.---WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH

County of Power

City of American Falls

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Registration District No. 23

Primary Registration District No. 2302

DO NOT WRITE IN THIS SPACE

State File No. 80753

Local Registrar's No. 24

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

50

2. FULL NAME Ethel Lusher

(a) Residence. No. American Falls, Idaho St. .....
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Jan. 27, 1877

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55	7	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookeeper, etc .....

9. Industry or business in which work was done, as silk mill, saw mill, bank etc Teacher

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation 20

12. BIRTHPLACE (city or town) (State or country) Wain County, Iowa.

FATHER

13. NAME H.H.Lusher

14. BIRTHPLACE (city or town) (State or country) Vananamo, Penn

MOTHER

15. MAIDEN NAME Lucy Mitchell

16. BIRTHPLACE (city or town) (State or country) Penn.

17. INFORMENT (Address) Mrs. O.K. Pollard

18. BURIAL, CREMATION, OR REMOVAL
Place American Falls Date Sept. 12 1932

19. UNDERTAKER Ann Davis
(Address) American Falls Ida

20. FILED 9-12, 1932 Genevieve Nold
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Sept 11 1932

22. I HEREBY CERTIFY, That I attended deceased from June 21, 1932, to September 11, 1932
I last saw her alive on September 10, 1932; death is said to have occurred on the date stated above, at 7:40 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral tumor	

Other contributory causes of importance:

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ~ Date of injury ....., 193.
Where did injury occur? ~
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. .....
Manner of injury ~
Nature of injury ~

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) V.V. Lyon, M. D.
(Address) .....

RECEIVED JAN 16 1933

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 81770

PLACE OF DEATH
County of Gooding
City of ~~Gooding~~ R.F.D. Wendell

Registration District No. 22
Primary Registration District No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

Local Registrar's No.

182

2. FULL NAME Leo Darald Stevens

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word): Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE: Years 1 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None — Baby
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (city or town) (State or country): Jerome Ida

PARENTS
10. NAME OF FATHER: Arnold Stevens
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Rachel Pearson
13. BIRTHPLACE OF MOTHER (city or town) (State or Country): Utah

14. Informant: A. Stevens
(Address) Jerome Idaho R.F.D.

15. Filed Jan 16, 1933 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19, 1930, to July 19, 1930
that I last saw him ~~alive~~ on July 19, 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
— Drowning in irrigation ditch
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. P. Zeller, M. D.
7/21, 1930 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal: Jerome Ida
Date of Burial: July 21 1930

20. Undertaker: Sweets, Furniture Store
Address: Jerome Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

RECEIVED DEC 19[illegible]

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 86648

PLACE OF DEATH
County of Gooding
City of Wendell

Registration District No. 12
Primary Registration District No. 2018
Local Registrar's No.
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME William Hastings O'Brown

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rose Brown

6. DATE OF BIRTH (month, day and year) June 23.

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pool Hall Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Penn

PARENTS
10. NAME OF FATHER Hunter Brown
11. BIRTHPLACE OF FATHER (city or town) (State or Country) Not Known
12. MAIDEN NAME OF MOTHER Gunn
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Not Known

14. Informant W A Brown
(Address) Wendell Idaho

15. Filed Jan 29, 1930. E. L. Simonton Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 28 1930
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Jan 28, 1930
that I last saw h[illegible] alive on Jan 26, 1930
and that death occurred, on the date stated above, at 2:00 a.m.
The CAUSE OF DEATH* was as follows: Cancer of the face

(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Dr's None
(Signed) E. L. Simonton, M. D.
Jan 29, 1930 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
Wendell Idaho	Jan 19
20. Undertaker Geo Smith	Address Wendell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

N. B.--WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

11

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 91691

PLACE OF DEATH
County of Lemas Co
City of Fairfield

Registration District No. 58
Primary Registration District No. 2138 Local Registrar's No. 58

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Reece C. Boyer

(a) Residence. No. ..... St. .....
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. Color or Race: W
5. Single, Married, Widowed or Divorced (write the word): Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Eunice Boyer

6. DATE OF BIRTH (month, day, and year): Can't tell no record

7. AGE: Years: 65 | Months: | Days: | If LESS than 1 day,... hrs. or ..... min.:

OCCUPATION
8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper, etc.**: Farmer
9. Industry or business in which work was done, as **silk mill, saw mill, bank, etc.**: Own Farm
10. Date deceased last worked at this occupation (mo. and yr.): 1914
11. Total time (years) spent in this occupation: Since a boy

12. BIRTHPLACE (city or town) (State or country): Pocok Virginia

MOTHER FATHER
13. NAME: Dont Know
14. BIRTHPLACE (city or town) (State or country): Dont Know
15. MAIDEN NAME: Dont Know
16. BIRTHPLACE (city or town) (State or country): Dont Know

17. INFORMANT (Address) .....

18. BURIAL, CREMATION OR REMOVAL
Place ..... Date ....., 193..

19. UNDERTAKER (Address): No undertaker employed by own folks at Fil City

20. FILED ....., 193.. M B Parkinson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year): June 10 1930

22. I HEREBY CERTIFY, That I attended deceased from ....., 193...., to ....., 193....
I last saw h...alive on ....., 193...: death is said to have occurred on the date stated above, at .....m.
The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Apoplexy	May 25-1930

Other **contributory causes** of importance:

Previous Stroke, one one again	1914 1926

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy?...

23. If death was due to external causes (violence) fill in also the following:
Accident, Suicide or Homicide? ..... Date of injury, 193..
Where did injury occur? .....
(Specify city or town, county, and state)
Specify whether injury occurred in **industry**, in **home**, or in **public place**. .....
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify.....
(Signed) ....., M. D.
(Address) .....

This was a case of Apoplexy at the time of death. I was not present at the time of death or present at the funeral. M B Parkinson

SEP 7 1935 RECEIVED

PLACE OF DEATH

County of Valley

City of Cascade

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE

State File No. 695148

Registration District No. 15

Primary Registration District No. ..... Local Registrar's No. 15

(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

193

2. FULL NAME Raymond Hamilton Robertson

(a) Residence. No. 805 North 18th, Street St. Boise, Idaho
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. Color or Race White
5. Single, Married, Widowed or Divorced (write the word) Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Robertson

6. DATE OF BIRTH (month, day, and year) Dec 16 1874

7. AGE Years 55 Months 9 Days 20 If LESS than 1 day,... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as **spinner, sawyer, bookkeeper, etc.** Salesman
9. Industry or business in which work was done, as **silk mill, saw mill, bank, etc.** General
10. Date deceased last worked at this occupation (mo. and yr.) .....
11. Total time (years) spent in this occupation 10 yrs

12. BIRTHPLACE (city or town) (State or country) Centralia Illinois

FATHER
13. NAME Thomas Robertson
14. BIRTHPLACE (city or town) (State or country) Penn

MOTHER
15. MAIDEN NAME Elizabeth Breakhouse
16. BIRTHPLACE (city or town) (State or country) Ohio

17. INFORMANT (Address) Mabel Robertson Salt Lake City Utah

18. BURIAL, CREMATION, OR REMOVAL Morris Hill Cemetery Date 8/29/35

19. UNDERTAKER (Address) Wm. McCartney

20. FILED Sept 31, 1935 Montana G. Ready Registrar.

By Myrtle M. Gardner

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and year) Probably Oct 6th, 1930

22. I HEREBY CERTIFY, That I attended deceased from ....., 193...., to ....., 193....

I last saw h....alive on ....., 193...: death is said to have occurred on the date stated above, at .....m.

The **principal cause of death** and related causes of importance were as follows: **Date of onset**

This man was lost in the mountains while on a hunting trip. Remains discovered nearly 5 years later. Cause of death unknown.

Other **contributory causes** of importance:

Exposure.

There was about 5 inches of wet snow fell while he was lost the first night.

Name of operation..... Date of.....

What test confirmed diagnosis?.... Was there an autopsy?..

23. If death was due to exter'l causes **(violence)** fill in also the following:

Accident, suicide, or homicide?..... Date of injury.., 193.

Where did injury occur?.....
(Specify city or town, county, and state)

Specify whether injury occurred in **industry**, in **home**, or in **public place.** .....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No. If so, specify.....

(Signed) Roscoe C. Ward M.D.
Coroner Valley County
Cascade Idaho

MARGIN RESERVED FOR BINDING

N. B.---WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

96363

PLACE OF DEATH
County of Burley
City of Cassia

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 96363

JAN 9 1936 RECEIVED

Registration District No. 117
Primary Registration District No. 2196 Local Regisrar's No. 233-a
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number)

101a

2. FULL NAME Martha Downs Worthington
(a) Residence. No. Burley Ida St.
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. Color or Race white
5. Single, Married, Widowed or Divorced (write the word) married
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of
6. DATE OF BIRTH (month, day, and year) June 1862
7. AGE Years 68 Months 7 Days If LESS than 1 day ..... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (mo. and yr.)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) England

FATHER
13. NAME John Downs
14. BIRTHPLACE (city or town) (State or country) England

MOTHER
15. MAIDEN NAME unknown
16. BIRTHPLACE (city or town) (State or country) England

17. INFORMANT (Address) Percy Worthington
18. BURIAL, ~~CREMATION OR REMOVAL~~
Place Burley Idaho Date Dec 30, 193..
19. UNDERTAKER (Address) W. A. Goodman Rupert Idaho
20. FILED 12-26, 1935 Laura G Spracher Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day and ~~year~~) Dec 27 1930
22. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1930, to Dec 27, 1930
I last saw her alive on Dec 24, 1930: death is said to have occurred on the date stated above, at 7:30 A m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	
Other contributory causes of importance:	

Name of operation None Date of
What test confirmed diagnosis? Was there an autopsy? No
23. If death was due to exter'l causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 193..
Where did injury occur? (Specify city or town, county, and state)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? If so, specify
(Signed) Leland Frazier, M. D.
(Address) Burley Idaho

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

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FEB 11 1936 RECEIVED

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 97006

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Center
City of Bayhorse
Bayhorse

Registration District No. 10
Primary Registration District No. 2186 Local Registrar's No. 203
(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Leroy Tracht.

(a) Residence. No. St.
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. Single, Married, Widowed, or Divorced (write the word.): Married.

5a. If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ J. Eileen Frazier

6. DATE OF BIRTH (month, day and year) May 12, 1891

7. AGE: 28 Years | Months: 9 | Days: 4 | If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Mining
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): Clayton Idaho

PARENTS

10. NAME OF FATHER: C. L. Tracht
11. BIRTHPLACE OF FATHER (city or town) (State or Country): Gallion Ohio
12. MAIDEN NAME OF MOTHER: Ida Marlatt
13. BIRTHPLACE OF MOTHER (city or town) (State or County): Oregon

14. Informant (Address): Mrs. LeRoy Tracht

15. Filed Jan 30, 1936. Edna McKenney Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 2 a m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18. Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) C. L. Hartley M. D.
2/9, 1936 (Address) C. Nampa Ida

19. Place of Burial, Cremation, or Removal: Nampa Ida | Date of Burial 19

20. Undertaker | Address

PLACE OF DEATH
County of Shoshone
City of Near Mullan

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 111021

Registration District No. 70
Primary Registration District No. 1011
Local Registrar's No. 30

(No. 167)
(If death occurred in a hospital or institution, give its name instead of street and number)

2. FULL NAME Harry Wilcox (Tubby Wilcox)

(a) Residence No. Mullan Ida St.
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX	4. Color or Race	5. Single, Married, Widowed or Divorced (write the word)
Male	White.	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
22			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Miner.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (mo. and yr.)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Not Known
(State or country)

FATHER

13. NAME "
14. BIRTHPLACE (city or town) "
(State or country)

MOTHER

15. MAIDEN NAME "
16. BIRTHPLACE (city or town) "
(State or country)

17. INFORMANT Friends.
(Address)

18. BURIAL, CREMATION OR REMOVAL
Place Spokane Wn. Date Apr 10, 1930

19. UNDERTAKER J. A. Bower (Undr.)
(Address) Wallace

20. FILED Apr 15, 1930 John A Bower
Registrar.

MEDICAL CERTIFICATE OF DEATH.

21. DATE OF DEATH (month, day and year) March 1930

22 I HEREBY CERTIFY, That I attended deceased from ....., 193....., to....., 193.....

I last saw him alive on ..... 193.....: death is said to have occurred on the date stated above, at ..... m.

The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Bowel trouble & Skin disease	
Liver trouble & Jaundice	
Pneumonia about 1 day	
Age about 1 year.	

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to exter'l causes (violence) fill in also the following:
Accident, suicide or homicide? Date of injury, 193.....
Where did injury occur? (Specify city, town, county, and state)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24 Was disease or injury in any way related to occupation of deceased? If so, specify
(Signed) .....
(Address) .....

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 131638
Registrar's No. 221

DEC 11 1942 State of Idaho

1. PLACE OF DEATH:
(a) County Nez Perce
(b) City or town Spalding (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: At home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether In this community 2 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Idaho (b) County Nez Perce
(c) City or town Spalding (If outside city or town limits, write RURAL)
(d) Street No. ____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? 109 years.

3. (a) FULL NAME LEROY PINKHAM
3. (b) If veteran, name war INFANT
3. (c) Social Security No. ____
4. Sex Male
5. Color or race Indian
6. (a) Single, widowed, married, divorced single
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased 11-29-30 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
1	5	11	hr. ____ min.

9. Birthplace Spalding, Idaho (City, town, or county) (State or foreign country)
10. Usual occupation Infant
11. Industry or business ____

MOTHER
12. Name Alexis Pinkham
13. Birthplace Nez Perce Reservation (City, town, or county) (State or foreign country)
14. Maiden name Annette Blackeagle

FATHER
15. Birthplace Spalding, Idaho (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Annette Pinkham
(b) Address Lenore, Idaho
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11-30-30 (Month) (Day) (Year)
(c) Place; burial or cremation Spalding, Idaho.
18. (a) Signature of funeral director Brower-Mann
(b) Address Lewiston, Idaho
19. (a) Nov. 12, 1942 (Date received local registrar) (b) Margaret Vassar (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month November day 29th,
year 1930 hour ____ minute ____
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____:
that I last saw h____ alive on ____, 19____:
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: This is a delayed certificate	
and the doctor who attended the	
Due to child is not available, but	
it is the memory of the parents that	
Due to the cause of the death was	
Pneumonia	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
23. Signature George Gaignard (M. D. or Coroner)
Address Culdesac, Idaho Date signed ____

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